Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 7-30A NKENE Month V ANIEL 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Northwest Seasons Hospice Baltimore Randallstown . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) Country) Director 729-07-5902 1 🛛 M 2 🗆 F Ngwó Cameroon 48 01/29/1964 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours efter death with the Merylend ment of Health end Mentel Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examinar must be mutilial at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges MD Laurel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9102 Huntington Ct. Apt. X3 20708 Cameroon 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Securitas 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mbengwi Ankene Frida Aboh Ankene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Ntah (Sister) 9102 Huntington Ct. Apt.X3 Laurel,MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of important: if it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) 12/1/12 Ngwo-Cameroon Ankene Fam. Cem. Name and Address of Facility Joseph H. Brown, Jr 2140 N. Fulton Ave. Signature of Fuperal Service Licen Jr. Funeral e. Balto. MD OW 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ UNCT ANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir After this certificate has been signed by the ettending physicien and if funerel director, pege 2 should be detached for use es the burlal-transit Physician: The lew requires that the death certificete be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1/2 No Yes 2 No 1 Yes To the Hospital or Attending Physician: Within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Dallell P No Hospital Other: ျှ 1 🗌 Yes mce 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 5 Other (Spe 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28591 anny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.D 1525 OWINGS MILL ASNEEM 1000 mo 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

NUA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08246 State of Maryland / Department of Health and Mental Hygiene Michael Allen, Jr. Certificate of Death 1. For State Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day 1341 hrs Allen October 31, 2012 Medical Examiner Michael Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** Days Hours Min Months 03-20-1971 Maryland Director 215-78-4164 41 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No a or 28a-f show Baltimore Parkville Maryland death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 8212 Laurel Drive 23a noti 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. unera If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married Yes 2X No ũ Specify: Black If Yes, Give Year Yes 2 X No specify: filed within 72 hours after Widowed Divorced \$ 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 other than Bus Technician Fleetpro, Inc. 12th grade es I and 2 should be filed within of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Anthony Allen Sr. Yvonne Hughes marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 8212 Laurel Drive Parkville Maryland Kimberly Allen If item 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, permit. Pages 1 and crematory or other place) 1X Burial 2 Cremation 3 Removal from State 11/10/12 Windsor Mill, MD. King Memorial Park Important: Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD. 21206 21 Signature of Funeral Service Licensee 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medica) Death a Gunshot Wound of Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit cian/Medical UNPENDED AMENDED 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. Yes 2 ✓ No 3 Probably 4 Unknown ğ Completed Records, 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy performed? death? No Yes 2 No 1 🗸 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Fo the Hospital or Attending Physician: of Vital Be Other<sub>4</sub> Hospital: 1 / Inpatient Nursing Home 5 Residence 6 ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred After 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Certification: Oct 30, 2012 Subject shot 1715 hrs Natural 1 Yes 2 ✔ No Division Pending the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. in by within 24 hours after c To the Funeral Direc Could not be 3 or Town, State) 1100 block of Homewood Avenue, Baltimore, MD Suicide determined (Specify) Local Street 4 1 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 1, 2012 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Carol H. Allan, MD

State Registrar

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35503 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 6:30 AM George Sylvester Allen Sr. 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mospital of Bal Balhmore timore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours Director 217-24-5010 1 XM 2 □ F 83 yrs. 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho ortent: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other treumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4149 Fairview Avenue 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced specify: African-American 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver National Can Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ John O. Allen Ruth Molten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6139 N. Hill-Mar Circle, Forestville, MD 20747 Deborah I. Johnson/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it eny Injury or o 1 KBurial 2 Cremation 3 Removal from State 11-10-2012 4 Donation 5 Other (Specify) Arbutus Mem. Park Arbutus, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 5200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part 1. Enter the dis mmediate Cause (Final Respiratory Onset and Death Physician/ disease or condition Medical resulting in death) Examiner lemstatic 12hours Sequentially list conditions, Physician/Medical Examiner If any leading to immediate cause. Enter Underlying Cause injury Disk to (or as a consequence or) or Attending Physicien: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use es the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physicien: The law within 24 hours after death.

To the Funerel Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📈 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Turen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of H <i>rtificate of L</i>			giene leg. No. 20	12 35504
	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Dea Month		3. Time of Death
~~	/Medic	al	4a. Facility Name (If not institution, give	ABIE				OCT		2012 4:30 AM
and the	Examir	er	GOOD SAMARI		A.	4b. City, Town, or Baltimor			4c. County of Balti	
***	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign
	Director		None	□м 2XF Unknow	n Yrs.	Months Days	Hours Min.	Unknown		Cameroon
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
	Maryl f sho	to								1 ∑Yes 2 □ No
	r 28a	Director	MD Howard  10e. Street and Number		lumbia	10f. Zip Code		1	0g. Citizen of W	/hat Country?
	th with	alD	8839 Stone Brook	Lane		21046			Cameroo	n
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	e - American Indian, k, White, etc.
36	or i	by F	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 ∐Yes 2√7 No If Yes, Give Year or Dates:		□Yes 2X No	Specify:	. ,		Black
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Experience out be notified at		15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bus	siness/Industry
218	thin 7: e. an "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give i	kind of work done d OO NOT use retired)	uring most of worki	ing		
21	ed wii ygien yer th	S	12yrs		Teacl		· ·		Priv	
and	be fill ntal H ed otl ed otl	Be	17. Father's Name (First, Middle, Last)  Raphel Atieyim				18. Mother's Name			a)
Z	hould nd Me mark matic	은	19a. Informant's Name/Relationship (7	Syna Print)	10h Mailin	g Address (Street a		cia Ngwe		Change Tim Conday
Z	nd 2 salth ar 27 is r trau		Patricia Fornish:			Stonebro				
Jre,	of Hear item		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of place	, ,			City or Town, State
<u>=</u>	Page ment ant: If ury o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	amily_			1/2012	Akum, C	ameroon
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modeal Exprintmet" ust be notified at once.		21. Signature of Fundal Service Licen	see		. Name and Address				ral Home, Inc.
	<u> </u>		Charge arse							, MD 20785
		P 51	23a. Part 1. Enter the disease, or comp shock of heart failure. List only of Immediate Cause (Final					or respiratory arr	est,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Sepsis  Due to (or as a consequ	Sy	voow	e			
	Examiner			bue to (or as a consequence to Health	uence or):	2011	9 Gala	Λ₽		
1	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uerice of).	*(4)00		. (00)	0214	
to	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с						
60,	ficate be executed physiclan and s the burial-transit	a E	resulting in death) East	Due to (or as a consequent	uence of):					
68760		edical		d	-					
	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as to	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date	e of delivery
B	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Mon	nth Day Year
Р.	uires that the de	Phy	9 Unknown		hr			The Pile		
ds,	signe signe d be d	þ	Part II. Other significant conditions of	Ontributing to death but not rest	uting in the un	deriying cause giver	n in Part I.			ibute to the cause of death? 3 ☐ Probably 4 X Unknown
CO	w requir s been si should I	Completed	Anasaica	·				1		
æ	he lav te has age 2	duc	// 15 W-3 W/ C W					24a. Was a autops perforr	ned? pr	Vere autopsy findings available rior to completion of cause of eath?
<u>ta</u>	sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical				26. Place of Death	1 ☐ Yes		□Yes 2□No
<u>&gt;</u>	hysic his ce I direc	일	examiner? 1 ☐ Yes 2 🔁 No	Hospital: 1 🔼 Inpatient 2 🗌	ER/Outpatient				·	or (Specify)
<u> </u>	ing P	ö	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work?			w injury occurre	
Sic	ttend death stor: / the f	icati	2 Accident investigation 3 Suicide 6 Could not be	COn Diagnot Injury At he			es 2□No	201		
Division of Vital Records, P.O. Box	after after Direc	ertification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, iarm, stre	et, ractory, office	2	City or Town	reet and Numbe n, State)	er or Rural Route Number,
		a C	29a. Certifier 1 Certifying Phy	rsician: To the best of my kno	wledge, death	occurred at the time	e, date and place,	and due to the c	ause(s) and mar	nner as stated.
	the Ho lin 24 the Fu	Medical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	inion, death occurr	ed at the time, d	ate and place, a	nd due to the cause(s)
	To t	Σ	29b. Signature and title of certifier			29c. License		1		(Month, Day, Year)
			In he had		MD		70832		JOE 2 0	1,2012
	3		30. Name and address of person who comoth Amm & D G	ompleted cause of death (Item			TAIN	7 # 10	U B ALL	more MD 21201
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture		VI HON ?	יעב די	0 0017	har DIE 14/TI TIER
	Registra		NOV 0 7 2012	General B. A.	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gerald Thoms Avaritt 4:59 Ам 01, November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3534 Mill Green Road Harford Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Baltimore Days (Month, Day, Year) Months Hours Min. 213-52-6159 **Director** 1 X M 2 □ F Yrs 63 Aug. 07, 1949 Maryland Usual Residence of Deced show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28e∙f sho the Medkal Evarrimer must be πutfied at Director 1 ☐ Yes 2 🔀 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3534 Mill Green Road 21154 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Even 11 0.0. Armed Forces? 1 ☑ Yes 2 ☐ No 1964— If Yes, Give 1968— Year or Dates. Vice Tham Warm Black, White, etc. 1 Never Married 2 X Married ş Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruth Smith Richard Avaritt Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeruld Saltimore, N 3534 Mill Green Road, Street, Maryland 21154 <u>Mrs. Deborah Avaritt (Spouse)</u> If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State November 05, permit. Page Department of Importent: Meny injury or once. Gardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland 2012 eral Service Licensee Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air Texture (MD1543) 3 Newbort Drive, Forest Hill, Maryland 21050 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Eul a th d se, or complications that caused shock, or heart follure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oronary Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: Exami ettending physician end for use es the burial-transif The law requires that the death certificate be executed Cause (Disease or injury jabe te that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\[ \]$  Residence 6  $\square$  Other (Specify) Hospital 1 Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No erel Director: A filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined ò City or Town, State) within 24 hours To the Funerel Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the Masis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitions—To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number lar 30. Name and address of person who completed cause of death (Item 23a) (Type, Privit) 9106 311 om5 filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:16 P M November Anthony Robert Astorino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 6655 Middleburg Rd. Keymar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 17, 1957 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours Min Pennsylvania 196-50-6433 55 Director Usual Residence of Decedent Show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Funeral Director 28a-f 1 Yes 2 X No Carroll Keymar Maryland 10g. Citizen of What Country? 10f. Zip Code ŏ 10e. Street and Number items 23a U.S.A. 21757 6655 Middleburg Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Forces? 9 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) construction 12 estimator service other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked of ပ Page 1 and 2 should be Carmine Buondi Anthony S. Astorino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Gettysburg, PA 17325 894A Marsh Creek Rd. Anthony D. Astorino/ son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State ŏ Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 11/3/2012 Sykesville, MD Signature of Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home, P.A. New Windsor, MD 21776 P.O. Box 249 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ➡Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\mathbf{X}$  Residence 6  $\square$  Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death uneral Director: A Accident Investigation Could not be completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Examiner: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) MarchesterRJ State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2301 M 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, 4c. County of Death Examiner A WASh med 10 VNU 0 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number . Age (In yrs. last birthday) Funeral (Month, Day, Year) Days Hours Country) -463 **Director** 1 M 2 F ITGINIA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD 0 ON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral S . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married by 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Blac Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) condary (0-12) College (1-4 or 5+) Elementary/Se Salesper Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ပ State, Zip Code) 21113 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 1630 Q 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ElKridge Meadowrid 92 1HD-2012 4 ☐ Donation 5 ☐ Other (Specify) owel 21. Signature of Funeral Service Licensee 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 0 440 0 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 1 Yes 2 W 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occu rred at the time, date and place, and due to the cause(s) and manner as stated. puti 29b. Signature and title of certifier 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ber Usaco Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Johns Hopkins Itospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year 12/23/73 N/A Director 1 X M 2 □ F Kuwait Usual Residence of Decedent 28e-f shov 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Owings Mills 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10010 Cascade Falls Court 21117 Kuwait 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Never Married 2XXMarried Completed by 1 ☐ Yes 2 🗖 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Caucasian 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 27 is merked other then treumetic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 IT Engineer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hamad Alshammari Kindila Alshammari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KuwaitCity Abdula Al Mubarak Block 9 Street 922 House 26 Kuwait Ebtesam Alshammari / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Kuwait City Cemetery Nov. 9,2012 Kuwait City, Kuwait 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenset Victor P. Doda, Jr22. Name and Address of Facility \*Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To this Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burlei-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Unlatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn Warner MD 1800 Orleans St. Baltimore, MD.21287 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Mary Lou Atkins 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Season's Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs, 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 X 214-38-3263 Yrs 06/16/1938 74 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore Windsor Mill ms 23a or 28a-f s must be notified 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Pasture Rose Court 21244 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ŏ þ 1 X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed "natural" 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than the M Elementary/Seconday (0-12) life. DO NOT use retired) Al Hygiene.
Ad other tha College (1-4 or 5+) Private Duty Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 27 is marked of traumatic ever ပ Coleman Atkins Louella Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 3 Pasture Rose Court Windsor Mill, MD 21244 Sean L. Lee / Son Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Cremation Ctr of MD 11.05.2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) John L. Williams Funeral Directors, P.A. 4517 Park Hights Ave Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. THROMBOSIS Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to for as a conse, uence of cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed ☑ No Yes funeral director, 25. Was case referred to predical Wha 1 Reel 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: filled in by the Suicide 6 [ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, asueun V 38201

DHMH 17 Rev 7/2009

State Registrar vocio.

1521

WINGS MILL MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

2-08039		Please Type or Print in Black Indelible In	k. Ensur	e All Cop	ies Are Le	gible.	
aron Tavonte Bell State of Maryland / Department of Health and Mental Hygiene							35510
		I- For State Certificate of L		Reg. No.			
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)  Laron Tavonte Bell			2. Date of De Month October 2	Day Year	3. Time of Death 1512 hrs
		tal resimily reality (in the meaning give and a series)	o. City, Town, or Abingdon	Location of De	eath	4c. County of Death Harford	
Funeral	4	5, Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Yea	r If Under 24	Hrs. 8. Date of B		thplace (State or
Director		218-27-4945 <sub>1XM 2F</sub> 22 <sub>Yrs.</sub>	Months Day	s Hours M	vin. 01/0	3/1990 Foreign	Maryland
kue	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limits
	<u>_</u>	Maryland Harford Abingdon					1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "matural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	4	10e. Street and Number 3702 Trail Wood Court	10f. Zip Code 21 0 0 9			10g. Citizen of What Cou USA	ntry?
with th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was			( Specify Yes or N		can Indian, Black,
er death	Funeral	1 Yes 2 X No	s, specify Cubar		erto Rican, etc.)	White, etc.  Specify: Bla	ck
rs afte	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's			of work done	16b. Kind of Business/	
5 72 hou in "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life Clerk		retired)	Gamestop	
21215-0036 and be filed within 72 Mental Hygiene. marked other than c event, the Medical	틹	12th grade			me (Eiret Middle	Maiden Surname)	_
15.		17. Father's Name (First, Middle, Last)  Leroy Bell			na Matt		
2121 Ald be fil Mental I marked c event,	<b></b>					ımber, City or Town, State	, Zip Code)
and 2 shou fealth and IN tem 27 is in traumatic		Loretta Oliver/Grandmother 3702				gdon,MD.21	009
re, M s 1 and 2 of Health If item 2	ſ	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other	er place)	· I	Date	20c. Location - City or	
imore Pages 1 ment of H unt: If i		4 Donation 5 Other Specify:				2 Dundalk,	
Baltimore, permit. Pages I an Department of Hee Important: If ite	- [		ame and Addres			-Harris Fu more Maryl	neral Home
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the					Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Could Not Be Determine)	ned				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):					
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					-
X	Examine	cause. Enter Underlying Cause (Disease or imply that imitated events resulting in death) Last  Due to (or as a consequence of):	-				-
ecuted and - transit		d		20 11 1	. 10		-
be exe	dic	▼ UNPENDED	r me,g9	33 11-1	4-12 sm		<u></u>
Box 68760, e death certificate be extended the attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the 2 Section 10 December 2 Section 2 December 2 Section 2 December 2 Section 2 December 2	al death 3	Ectopic pre	gnancy	23d. Date of deliver Month	V Day Year
th cert	icia	past 12 montries?  4 Pregnant at time of death 5 Other	er (Specify)			şļ.	,
D. Bc the dea by the a	à là	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause	niven in Part I.	23e. Did	tobacco use contribute to	the cause of death?
, P.O. B res that the de signed by the be detached is	۵				_ 1 _ Y	es 2 No 3 Pro	oably 4 🗹 Unknown
ords, w require s been si should b	etec				24a. Was		topsy findings available completion of cause of
eco he law ate has	Completed					ormed? death?	
Vital Recc ysician: The lav his certificate ha	Be C	25. Was case referred to medical	26.Place	of Death (Che			
of Vit ing Physic After this c	리	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27 Manner of Death  28a. Date of Injury  28b. Time of Injury		Other Nu		Residence 6  Othe	r: Scene
on of ading I th.	ë	1 Natural 5 Dending (Month, Day, Year)	1	Yes 2 X No	unknow	•	
Division of Vital Records, P.O. rate of Attending Physician: The law requires that it is after death.  al Director: After this certificate has been signed by the finneral director, page 2 should be detach.	Certification:	Accident  Accident  Suicide  Accident  Could not be  Suicide  Accident  Could not be	t, factory, office	ouilding, etc.		(Street and Number or Ru State) 1315 Har1	
Ospital ospital hours a		4 Homicide  29a Certifying Physician: To the best of my knowledge, death occurred from the control of the contr		ata and place	Abingd	lon,MD.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	on, in my opinio	n, death occurre	ed at the time, dat	e and place, and due to th	e cause(s)
E 2 E 8	¥	29b. Signature and title of certifier	29c. Licens			29d. Date signed (Mo	
		Carol Hallan	0.C.	M.E.		October 24, 201	Z
$\varphi$	1	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Carol H. Allan, MD Assistant Medical Examiner 900 W. B.</li> </ol>	altimore Str	eet, Baltimo	ore, MD 21223	3	

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Geneva Bost November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Golden Living Nursing Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 245-32-8134 88 Director 1 □ M 2 🗓 F Feb 27 1924 NC shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 2531 Arthur Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ TNO Specify Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) domestic homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Elizabeth Campbell ည Klutz L. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2531 Arthur Ave., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mr. Vann A. Bost (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
any injury or oth 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Memorial 11-9-12 Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Parge 2/aught 2 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) . ongestive Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: P this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Exami il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and 0 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) q | Unknown g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 횬 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar Signatore and title of certifie

acqueline

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

EARN

069707

00/2

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:55 AM Judith Babette Berger 2012 October Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours Director 196-38-7318 1 🗆 M 2 🔀 F 63 08/02/1949 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Menyland Depertment of Heelih and Mentel Hygiene. Important: If item 27 is merked other than "neturel", or items 23e or 28e-f show any fujury or other traumetic event, the Medical Evan Inst. must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6115 Eastcliff Drive 21209 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 🖾 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Sudit, 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 4 Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Hermita Maier Hermann Berger, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 Bendon Road, Pikesville, Amy Hunovice / Friend-POA Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 11/05/2012 Hanover, Maryland 21. Signature of Fun Service Seesee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Ischemic Cardiomyopathy vears Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): e Hoapital or Attending Physician: The law requires thet the deeth carificate be executed 124 hours efter deeth.

24 hours efter deeth.

Puneral Director: After this certificate hes been signed by the ettending physician and letely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus, Chronic Kidney disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 No |@ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗀 No 1 Natural 2 Accident 5 Pending injury Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Pauline Scott RES 000 October 31,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BaltimoreMo M.D. Sinai Hospital of Baltimore, 2401 W. Belvedere Ave, Scott Pauline 21215 32. Registra's Signature State 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5.30 A M Physician/ November 20 Year Samuel Richard Barbee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Raven Community LIVING N/ABaltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. (Month, Day, Year) Director 215-12-5354 1 DXM 2 □ F 11/11/1922 Virginia 90 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified at.</u> 10b. County filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Funeral 5531 Nome Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Coast Guard Electrician <u>Curtis Bay</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Sarah Brooks John Henry Barbee permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 W. Lafayette Ave. Baltimore, MD 21216 Edward Alston (Stepson) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11/15/12 Baltimore, MD 4 Dogation 5 Other (Specify) Garrison Forest Sign turn of Funeral Service Lic 22. Name and Address of Facilit Brown Jr. Funeral Home PA 21217 2140 N. Fulton Ave. Balto., MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancer 121 ast Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran ed by the attending physicien and detached for use as the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 □ No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No After this certificate 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No To Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4050102 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manual of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M overwiser 3909 alt avo 30. Name and address of person who completed cause of 000 Kaven av and 32. Registrar's Signature State Registrar

arbe

 $\propto$ 

200

a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Brown Month 11 2012 10:10a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Ritchie Hospice Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 260-30-2775 Director 1 XM 2 IF 85 Yrs. 04/08/1927 Carolina 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho the Medicel Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 2026 E. 31st Street 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 XNever Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 NNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other than any injury or other treumetic event; the any injury or other treumetic event; the angles. UNK UNK UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ella Toraine (Care Prov.) 2026 E. 31st St. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 11/7/12 Baltimore, MD 21. Signature of Fundal Sovice Licer see 22. Name and Address of Facility
Joseph H. Brown Jr.
2140 N. Fulton Ave. Funeral Balto., 21a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after cleath. Funeral Director: After this certificate has been signed by the attending abused to the attending abuse to be attended to be attended as a beginning and a second account of the attended as a second account of the attended account Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown cate has been signed by the a page 2 should be detached o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☒ No ☐ Yes 2 No Division of Vital filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier To the Hosp within 24 hou To the Funer completely fi Use Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowled je, death occurred at the time, data and place, and due to the name(s) and one must as stated 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) 05/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 6 . HAYES an State Registrar

10:11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 10-19-1921 Country 220-22-9464 Director 1 □ M 2 🗓 F VA 91 Yrs. The marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaniner must be notified at be filed within 72 hours after death with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d Inside City Limits Director MD Baltimore Gwynn Oak 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3105 Donna Road 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 Yes 2 No If Yes, Give Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: African-American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Agee Maggie Sharp 19a. Informant's Name/Relationship (Type, Print) auchter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Dean Boston Peacock Shelton 3105 Donna Road, Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e Department of H Important: If ite any Injury or ot 20c. Location - City or Town, State King Manorial Park 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-9-12 Woodlawn, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hromboscas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sate has been signed by the ettending physicien and page 2 should be detached for use es the burial-tren Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. 25. Was case referred to nedical Be 26. Place of Death (Check only one) Certificate: To 1 Yes / 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral DI Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number ess of person who completed cause of death (Item 23a) (Type, Print) State Registrar  $NUN_0$ 

P.O.

Records.

Division of Vital

### Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

			State of Maryland / [	Department of Hea	ith and Mental H	ygiene	0 16		
				Certificate of Dea	nth	Reg. No. 20   2	35516		
Phys	sicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of D	Death Day Year	3. Time of Death		
4	edic		BENJAMIN J. BOWLDING  4a. Facility Name (if not institution, give street and number)	JR.	ОСТОВІ	ER 30 2012	9:18 A M		
-Xa	min	er	506 70th Street	4b. City, Town, or Local Seat P1		4c. County of Deat			
Fune	eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If U	Jnder 24 Hrs. 8. Date of E	Prince G	thplace (State or Foreign		
Direc	tor		377 30 2073	rs. Months Days Ho	ours Min. (Month, E August	yay, rear) Co	untry) shington.DC		
ind whow	ē l	5	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location			10d. Inside City Limits		
Aaryla 8a-f s		Director	Md Prince George's Seat	Pleasant			1 X Yes 2 □ No		
the h			10e. Street and Number	10f. Zip Code		10g. Citizen of What Co			
h with	Ten	Funeral	506 70th Street	20743		USA			
deat r iten			11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No exican, Puerto Rican, etc.)	14. Race - Ame Black, White			
o36 s after ral", o		d by	1 ☐ Never Married 2 🗖 Married 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates,	1 ☐ Yes 2 🌠 No Sp	ecify:		Lack		
5-0 : hour		Completed	15. Decedent's Education 16a.	Decedent's Usual Occupation		16b. Kind of Business	Industry		
hin 72 he. than '		E O		(Give kind of work done during life. DO NOT use retired)	most of working				
d with		10 h	12th M 17. Father's Name (First, Middle, Last)	eat Selector		Private			
Maryland 21215-0036 12 should be filed within 72 hours after tith and Mental Hyglens 27 is marked other than "natural", o traumatic event, the Medical Exam		일	Benjamin J. Bowlding Sr.		Mother's Name <i>(First, Middle</i> nelma Taylor	e, Maiden Surname)			
ary nould ind M s mar				Mailing Address (Street and No		er City or Town State Zin	Cadel		
, Mid 2 sladth a salth a n 27 is eer tra		1	1	6 70th Street	Seat Pleasan	t,Maryland 2	20743		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other			20a. Method of Disposition  20b. Place of cemetery  20b. Place of cemetery	Disposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State		
timent trant:				n Cemetery	11/9/2012	Suitland, M	laryland		
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce.		21. Signature of Funeral Service Licensee	22. Name and Address of F	acility J.B. Jen	kins Funeral	Home, Inc.		
		$\dashv$	23a. Part 1. Enter the disease, or complications that caused the death. Do no		er Road Hyatt				
- Physicia	an/		snock, or neart failure. List only one cause on each line.  Immediate Cause (Final	rest,	Approximate Interval Between Onset and Death				
Medic	cal	ĺ	disease or condition resulting in death)  a.   Multiple Myelor Due to (or as a consequence of						
Examin	-	_	Sequentially list conditions, b.						
/ p #		<u> </u>	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying	):		12			
and ecute		Examiner	Cause (bisease or injury that initiated events c. Due to (or as a consequence of	vents c. ———————————————————————————————————					
ords, P.O. Box 68760 CA requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		dical	<b>L</b> <sub>d.</sub> _						
876 ificate ig phy as the		Med							
ords, P.O. Box 6870 requires that the death certificate been signed by the attending phenould be detached for use as the street of the control of the second for use as the street of the second for use as the second for u		~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	3 Fctopic pregnancy		23d. Date of deli	very		
Bo deat the at ned fo		SICI	1   Yes 2   No 4   Pregnant at time of death 9   Unknown 9   Unknown	5 Other (specify)		Month	Day Year		
P.O. that the ned by the detach	į		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in F	Part I. 23e Did	tobacco use contribute to	the course of death?		
S, F Lires the sign of sign of the sign of		D				Yes 2X No 3 ☐ Pro			
ecords s law requir has been a		Completed			24a. Was		opsy findings available		
Rec The la		Ę				psy prior to commed? death?	ompletion of cause of		
/ital Rec sician: The la certificate ha lirector, page 8			25. Was case referred to medical examiner?	26. Place of	Death (Check only one)	2 X No 1 ☐ Yes	2 No		
hysic physic this co	ļ.	2	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outp		Nursing Home 5 🙀 Resi	dence 6 Other (Specif	(y)		
ding F ding F h. After funer		Cerumoate	27. Manner of Death  1 ☒ Natural 5 ☐ Pending  28a. Date of Injury (Month, Day, Year)  28b. Tin	ry work?	_	now injury occurred			
SIO Atten r deat ctor:		Ĭ	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined	M 1 Yes		24	15		
DIVISION OF VITAI RECORDS, tal or Attending Physician; The law requires its after death.  al Director, After this certificate has been signed in by the funeral director, page 2 should b			4   Homicide determined building, etc. (Specify)	, street, rabidly, office	City or Tou	Street and Number or Rura vn, State)	Il Houte Number,		
DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	1.5	ealcal	29a. Certifier (Check  Check  Check	ath occured at the time, date a	and place, and due to the ca	use(s) and manner as stat	ed.		
the P thin 24 the F mplet	N	≥   <sub>−</sub>	only one) 3 Certifying Nurse Practioner: To the best of my knowled	ige, death occurred at the time,	date and place, and due to the	and place, and due to the ca se cause(s) and manner as s	ause(s) and manner stated. tated.		
- 4		2	29b. Signature and title of certifier	29c. License numb		29d. Date signed (Month,	Day, Year)		
U			30. Name and address of person who completed cause of death (Item 234) (Ty		1 +0	November	1, 2012		
			Gladys Heatley MD 6001 Landover F		sville,Maryla	and 20785			
	tate	3	31. Date file NOV 0 av 7 2012 32. Registrar's Signature						
Regis	_		32. Registrar's Signature	Mad.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3:30 A M George G. Belton 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Belair Autumn Assisted Living Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours 95 Director 243-09-5727 1 X M 2 □ F Vrs 25,1917 North Carolina Usual Residence of Decedent 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a, State filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Harford Belair Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 21014 1415 St. Francis Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2XXMarried à Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pege 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Company Estimator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Belton Edgar G. Hattie Cruchfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3805 Belmont Drive, Jarrettsville, MD 21084 Debra Beyer- Daughter in Law 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Evans Funeral Chapel
and Cremation Services 1 Burial 2XXCremation 3 Removal from State 11/3/2012 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the deeth certificate be executed sician and buriel-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burie Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed to page 2 should be det ρ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🕅 No After this certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) LIVING 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Movember 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOVO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician/ 00 ames Novemb 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 8. Date of Birth
(Month, Day, Year) 101 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours 220-12-4828 Director 1 反 M 2 □ F 86 Yrs. Balt., Maryland 1926 Usual Residence of Decedent 10d. Inside City Limits or then "naturel", or iteme 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.

Sent: If item 27 is merked other then "naturel", or iteme 23a or 28a-f shoury or other traumetic event, the Madical Evaluation must be notified at 10a, State Director 1 X Yes 2 No Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country?
United States 10e. Street and Number Funeral 21212 6225 York Road Apt.N313 of America Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2x No Specify: Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Post Office Mail Handler 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Bowman Phillip Byrd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Theresa Lee Shiner/dau. 9104 Deborah Avenue Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November permit. Page 1 6 Department of H cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State Importent: If any injury or Timonium, Maryland 7, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign fure of uneral Service Ligens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) talling Medical Due to (or as a consequence of): Examiner one umber Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The lew requires thet the death certificate be executed Diabete ettending physicien end for use es the burlal-trensi that initiated events Due to (or as a consequence of) resulting in death) Last Jomt Diceano Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death this certificete hes been signed by the ral director, page 2 should be deteched g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ he Hospitel or Attending Phys in 24 hours efter deeth. he Funeral Director: After this pletely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Soute 308 13 altimore Mp 821 N. BITAN IMASHMI MD SHDALLS A. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Year 2012 Physician/ AM 10:10 Joseph Binder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Sunrise Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) **Funeral** 554-42-1069 1 M 2 D F Director Yrs 4-5-1919 Poland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Director 1 X Yes 2 No Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20850 United States 8 Baltimore Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 Nidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) d Mental Hygiene. marked other than College (1-4 or 5+) 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than Sheet Metal Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e (Unknown) Shayna Joseph Ainbinder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Town Commons Court, Germantown, Maryland 20874 Irwin Binder 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 11-5-2012 Clarksburg, Maryland 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years nmediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner July 2012 Pontine Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Years Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Hypertension physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) e B 25. Was case referred to medical Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office

Box 68760 Division of Vital Records, P.O. eral Director: A filled in by the f

1 4 1 Homeic	determined	building, etc. (Specify)		City or Town, State)	
29a. Certifier (Check only one)	2 Medical Examine	inan: To the best of my knowledge, death oc r: On the basis of examination and/or investig Practitioner: To the best of my knowledge, d	ation, in my opinion, death occurred a	it the time, date and place, and due to	o the cause(s) and manner stated.
29b. Signature a	nd title of certifier		29c. License number	29d. Date signed (f	Month, Day, Year)

R. Mittalns rama

NOV

D0061382

10-31-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shama Ravi Mittal, MD - 14816 Physicians Lane, #152, Rockville, Maryland 20850

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 10 onth Physician/ 201 35 Rebecca Barach Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Montgomery Rockville Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min Days 132-12-3632 Director 91 1 M 2 X F 4-15-1921 New York Usual Residence of Dec 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Montgomery Rockville 1 X Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6105 Montrose Road 20852 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. o Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify "natural", 3 ☑ Widowed 4 ☐ Divorced White or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental မ Abraham Lehrer Clara Luber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Rochelle Kertzner - Daughter 138 Ryder Avenue, Dix Hills, New York 11746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o oonce. 1 X Burial 2 Cremation 3 Removal from State New Montefiore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11-4-2012 Farmingdale, New York 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Signature of Funeral Service Licensee Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ongestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown after death. I Director. After this certificate العدد المحالة المحال 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🔀 No Yes 2 **½** No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျ 1 Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Farli mina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

D0064871

Montrose Rd

10-24-12

MD

20052

City or Town, State

Rockville

Faz li

31. Date filed (Month, Day, Year)

4 Homicide

6/21 MO Registrar's Signature

DHMH 17 Rev 06-2011

State

Medical

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND 23A, 25, 27, 28A-F, PER ME, G954 8-12-14 SM State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 31 31 2012 Katherine T Bogulski 1250 M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept 12, Hours 1 □ M 2 🖵 F New York 066-12-4536 93 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Brookeville 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3409 Sinclair Court 20833 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 A No Specify: 3₺ Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Administrator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Zukowski Aniela Kalinowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Sinclair Ct. Brookeville, MD 20833 Susan Cottrell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 5-2012 4 ☐ Donation 5 ☐ Other (Specify) Springville, NY St. Aloysius Cemetery 22. Name and Address of Facility Signature of Funeral Service Licenses Metropolitan Funeral Service Vine Street Alexandria, VA 22310 5517 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Pnysician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

ပ

Examiner

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hen must he must hen must he must hen mu

Baltimore, Maryland 21215-0036

as the burial-transit attending physician nse ō the detached s been signed by t should be detach Completed by has page 2 s certificate completed filled in by the funeral director, Be within 24 hours after death.

To the Funeral Director: After this Medical Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Jamediate Cause (Final disease or condition	Advanced Dementia HIP FRACTURE		Onset and Death			
	resulting in death)	Due to (or as a consequence of);		1			
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of);	nonal Ho	O C CAN INER			
Talcal Fyd	that initiated events resulting in death) Last	Due to (or as a consequence of):	CERTIFICATION APPROVED	BY MEDICAL EXAMINER			
iyəlcidii iyle	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 N No 9  Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year			
red by r	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to						
odilloo			24a. Was an autopsy performed? 1 ☐ Yes 2 🔯				
Į.	25. Was case referred to medical	26. Place of Death (Che	eck only one)				
2	1 25 Yes 2 2 100		Home 5 Residence	6 ☐ Other (Specify)			
į	27. Manner of Death	28a. Date of injury 28b. Time of 28c. Injury at injury work?	28d. Describe how inju	ury occurred			
2	2 X Accident Investigation	10-8-2012 UNK M 1 □ Yes 2 X No	SUBJECT FE	LL OUT CHAIR			
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  NURSING HOME	28f. Location (Street a City or Town, Stat SANDY SPRI	nd Number or Rural Route Number, e) 17401 NORWOOD AVE. NG,MD.			
NO INC	(Check 2 Medical Examine	cian: To the best of my knowledge, death occured at the time, date and place, er: On the basis of examination and/or investigation, in my opinion, death occurred Practioner: To the best of my knowledge, death occurred at the time, date and p	at the time, date and place	e, and due to the cause(s) and manner stated.			

29c. License number

00069829

OFFICE PARK DRIVE, MONTGOMERY VILLAGE MD 20886

29d. Date signed (Month, Day, Year)

Registrar P DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

completed cause of death (Item 23a) (Type, Print)

18566

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Battle, Sr. Joseph 3:01 Medical vovember 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death La Plata Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 210-14-4995 87 Director 1 □XM 2 □ F Nov 6, 1925 North Carolina 28a-f shor 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Charles Waldorf 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11808 Murre Court 20601 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō þ 1 Never Married 2 Married 1 Yes 2 No Specify: Black. "natural" 3 Widowed 4 Divorced Specify: Completed WWII Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Steel Production Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental ! Important: If item 27 is marked o any injury or other traumatic eve ပ Fred Battle Sr Luvenia Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Battle - Son Waldorf, MD 20601 11808 Murre Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State McKeesport & Versailles 11/10/12 McKeesport, PA 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service Alexandria, VA 22310 5517 Vine Street If I Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical that the death certificate be as the l IF FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown detached for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy Yes 2 Hospital or Attending Physician; director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation after death Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old live center Ober 2075 31. Date filed (Month, Day, Year) State NOV 0 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3, 2012 Catherine C. Bonner 1745 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year) Hours Director 92 1920 Washington, D.C 578-16-9477 1 🗆 M 2 🗓 F July Yrs Usual Residence of Deceden r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3466 Chiswick Court #2B 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed ment of Health and Mental Hi tant: If item 27 is marked ot Edna M. Dant Leonard B. Thompson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1720 Timber Court Huntingtown MD 20639 William Russell Bonner, Jr/son Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Final Journey Crematory 11/07/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service
Beverly L. Heckrotte, P.A. Cla P.O. Box 784 MO1251 P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician a Metastatic Colon Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and sthe burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or injul that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 XNo Dav Pregnant at time of death 9 Unknown 9 Unknown P.0. been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed<sup>a</sup> 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🛭 Other (Specify) Hospital 1 Tyes 2 (No မ 1 Inpatient 2 ER/Outpatient 3 DOA this hospice 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide м within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 4, 2012 D60634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Bindu Joseph, M.D.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. dent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month tov Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 9, 1939 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Tennessee Director 412-64-2768 1 X M 2 □ F 73 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel North Beach 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20714 708 Walnut Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black. White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electronic Design Engineer Self Employed 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) vit. Pege 1 and 2 sh.

vnt of Health and Me.

'tem 27 is marked.

'r traumatic ev. မ Clifton Beverly Briley, Sr. Dorothy Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn D. Briley/wife 708 Walnut Avenue North Beach, MD 20714 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 a
Department of H
Important: If ite
any Injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/07/11 Woodbine, MD 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canc Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence ci); To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 🗹 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 🖳 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 Accident 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the st of my knowled e, death occur 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) venher 05 20/2 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Bari Irene Bergman Medical 2012 12:40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Health And Rehab Silver Spring <u>Montgomery</u> 8. Date of Birth (Month, Day, Year) 10/03/1944 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Director 1 - M 2 - F 067-26-7005 68 New York 28a-f shov 10b. County 10a, State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 901 Arcola Ave 20902 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Teacher</u> Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H Jack Bergman Ruth Lieblich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Sharon Acosta / Friend 12916 Falling Water Circle, #104, Germantown, MD 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/7/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Dorote Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erestorascular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day 9 Unknown detached 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No |은 1 Inpatient 2 ER/Outpatient 3 IDOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No within 24 hours after death. To the Funeral Director: Al completely filled in by the fu ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) my SHARMA CANDEEP 9701

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Mooth, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear BELCASTRO ATRICIA MART 00.18AM OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE MESICAL CENTER (CCC Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral Director** 216-68-7954 1 M 2 XF 52 10/21/1960 MD Usual Residence of Deced r 28a-f show notified at Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 Yes 2 XNo Bel Air 10e Street and Numbe or 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral USA 21014 5 Glenwood Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify and Mental Hygiene.
is marked other than "natural",
aumatic event, the Medical Exal Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Balto.Co. Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Patricia Jefferson Joseph A. DeLeonardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other 1770. 5 Glenwood Road, Bel Air, MD 21014 Jerry Belcastro - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 11/03/2012 Timonium, MD Dulanev Val. Mem'l Garden 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Signature of Funeral Service Licensee 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part i. Enter the disease, or complication shock, or heart failure. List only one cau s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each Jine. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ METAGTATIC BREATT CANCER TEALS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Beleastro, Patricia Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð PANCYTOPENIA 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 2 🗆 No 1 Yes ☐ Yes 2 🛣 N 180028340 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 SInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) OCTOBER.31. 2012 171 021338

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Mont

CHETALGAICE

HEALTH, BELAIR, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

121

UPPEL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Maryland	/ Department of Health and N Certificate of Death	lental Hygiene Reg. N	2012 25527	
			Registrar  1. Decedent's Name (First, Middle, Last)	0 11	Ochmodic of Bodin	2. Date of Death	3. Time of Death	
	Physicia Medic		Bridgette A	Babb		October 2	27 2012 6:59 PM	
	Examin	er	4a. Facility Name if not institution, give s	l medical Cent	4b. City, Town, or Location of Death  Battimore	4	c. County of Death	
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last		8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)	
	Director		2   8 - 8 6 - 2536   1   Usual Residence of Decedent	M 2 M F 43	Yrs.	1/2/196	,9 Maryland	
	yland -f shov ed at	ctor	10a. State 10b. County	10c. City,	Town or Location	,	10d. Inside City Limits 1 ☑ Yes 2 □ No	
	he Mar or 28a	Dire	10e. Street and Number	nore E	Stuynn Oak	10g. C	Citizen of What Country?	
	s 23a nust be	Funeral Director	5301 Norwo		21207		USA	
<b>'</b>	or death	by Fu	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
21215-0036	urs afte ural", al Exan		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 Yes 2 No Specify:		Specify: Black	
15-(	72 hor	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	Kind of Business/Industry	
	within ygiene. her tha t, the I		Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemaker		own Home	
and	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	Babb	18. Mother's Nam	e (First, Middle, Maider	KSON	
ary	should and Ma is mar aumati		19a. Informant's Name/Relationship (Typ		19b. Mailing Address (Street and Number or Rura			
e, S	and 2 s Health tem 27 other tra		Mrs. Karen J.  20a. Method of Disposition	lurner 20h Bla	2330 Monroe St.	Balto. Date 20c.1	MD 21217 Location - City or Town, State	
mor	Page 1 ment of ant; If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State cen	netery, crematory or other place)  NITY Lemetery 11/2		undalk, MD	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. St nature of uneral Service Line e		lame and Address of Facility	a Fineral	( Itome, P.A.	
_	0.0 = m ol		23a. Part 1. Enter the disease, or compl	cations that caused the death.	Do not enter the mode of dying, such as cardiac of		Approximate	
	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause on each line.	ndocarditis		Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):			
	MARCH.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to for as a consequen			104245	
	cuted ind transit	Examiner	Cause (Disease or injury that initiated events	Sepsis			4 weeks	
0	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	Due to (or as a consequer	nde oij.			
Box 68760	tificate ng phys	Medi	IF FEMALE:					
9 x c	eath certific attending p	clan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1  Live Birth 2  Fetal of 4  Pregnant at time of dea	death 3 Dectopic pregnancy		23d. Date of delivery Month Day Year	
Ö.	requires that the der been signed by the s should be detached	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown				
, P.O.	es that signed I be de	by	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause given in Part I.		o use contribute to the cause of death?  2   No 3   Probably 4   Unknown	
ords	v requii	Completed	Skin Mecrosis			24a. Was an	24b. Were autopsy findings available prior to completion of cause of	
Rec	The law ate has page 2	Com	Adrenal Insut	releven		autopsy performed? 1  Yes 2	death?	
ltal	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	26. Place of Death (Chec  R/Outpatient 3 DOA Other: 4 Nursing Ho		. □ O\\ \(\O\) = \(\frac{1}{2}\)	
of V	ng Phys ter this neral di	te: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		8b. Time of injury   28c. Injury at work?	ome 5 Residence 28d. Describe how inju		
sion	ttendir death. tor; Af / the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes 2 ☐ No	20f Location /Street a	and Number or Rural Route Number,	
Division of Vital Records,	al or A s after il Direc		4  Homicide determined	building, etc. (Specify)	ie, iaim, street, ractory, onice	City or Town, Stat		
	To the Hospital or Attending Physician; The law requires that the death certification within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Dedical Examin	er: On the basis of examination a	dge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurred a	t the time, date and plac	ce, and due to the cause(s) and manner stated.	
	To the within To the comple	Σ	only one) 3 Certifying Nurse 29b. Signature and fitle of certifier	Practitioner: To the best or my	knowledge, death occurred at the time, date and pl		Date signed (Month, Day, Year)	
D			· Carrup (u	Illiams, ACI	NP R115989	10	31/2012	
	ZV		30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  Kathyn Williams 22 South Green St. Bitmare, mp 21201					
E	Stat		31. Date filed (Month Day Year)	32 Registrar's Signatur				
	Registra	ग		- worms	· Marke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month heodore 99 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical Bultimore ure If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth 1 XM 2 🗆 Min. (Month, Day, Year) Unk. **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD N/A Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1041 William Street items 23a Funeral 21230 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 þ 1XXNever Married 2 Married Yes 2XX No Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 Xio Specify: "natural", White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A n N/A injury or other traumatic event, Be atth and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bruce Lee Benshoof Anna Rachel Herzfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce L. Benshoof /Father 1041 William Street, Baltimore MD 21230 1 and 2 s of Health a item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cremation Center of MD 10/19/2012 Hanover MD Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Extrem disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2 hrs 27 min Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: <u>ا</u> 1 Tes 1 PInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending NIA NIA 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) NA within 24 hours a

To the Funeral C

completed filled Medical 29a, Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 10/12/12

Registrar
DHMH 17 Rev 7/2009

State

Andrea Desa 31. Date filed (Month, Day, Year) Piace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5+

Paul

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month COUNTS MA OF: Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BONA PARTE Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 251-12-9093 Director 1 2 M 2 D F 94 Yrs. 05-28-1918 SO Department of Health end Mantal Hygiene. Importent: If item 27 is merkad other then "netural", or itams 23a or 28a-f eho eny injury or other traumatic avant, the Medical Evaninar must be notified at once. 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD BATIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral BONAPARTE AVENUE USA 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Be Completed by 1 Never Married 2 Married should be filad within 72 hours after Specify: AFRICAN 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Bothleham Steel SHIP FITTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HATTIE PERY JESSIE COUNTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREENE/DAUghter Bonaparte 907 Baltimore, Md. 21218 Page 1 and 2 Vonne Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖊 Burial 2 🗌 Cremation 3 🔲 Removal from State 11/12/12 Baltimore, Md Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE KINERAL SWS 11101557 York Road. BATIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) NEOFLASM OF 4074 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signad by the attending physicien and should be detached for use as the burlel-transit To the Hoepitel or Attanding Physicien: The lew raquires that the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Accident 5 Pending Investigation 6 Could not be filled in by the **Diractor**: 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number within 24 hours after To the Funarei Dirac City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29d. Date signed (Month, Day, Year) 30706 11/10/12 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

6:30PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ozetta 12.16PM Cason 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL OF BALTIMORE BALTIMORE NA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Yea 04-14-44 Days Min 212-42-1464 Director 68 1 M 2 X F MD Usual Residence of Deceder item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macked Evaniner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 229 N. Mount Street Apt.#014 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. . African Armed Forces?

1 Yes 2 No
If Yes, Give δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify American Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 Is marked other than "r mentary/Secondary (0-12) Mobile Craft Company 11th Grade Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Reynolds Betty Lewis Department of Health and Ment. Important: If item 27 is marriant linguity or any Injury or any Injur 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharrion Reunolds-Brown 3792 McDowell Lane Halthorpe, Maryland 21227 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD. National Cem. 11-10-12 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON ST ELEVATION MYDCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 4 DAYS SEPSIS BACTERIAL Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 as the attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day ed by the a detached i 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 8 OBSTRUCTIVE PULMONARY Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should METASTATIC BREAST CANCER, CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2\ No Yes 2V No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu death, 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 0 7 2012

MBBS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. APTE

NAphe

MBBS.

32 Registrar's Signatur

29c. License number

RES- 000

SINAI HOSPITAL

29d. Date signed (Month, Day, Year)

BALTIMORE

OF

VEMBER, 2, 2012

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month NOU Physician/ Medical 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death **Examiner** KOSS VILLE BACTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07-19-19/ Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 93 Yrs Months Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director BAUTIMORE 1 XX Yes 2 No MD APT 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral TARK 21206 USA MORAVIA 212 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 🗷 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE HouseKeeper UNK Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) : Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth Hancock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheatham 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any injury or c Department of 1 X Burial 2 Cremation 3 Removal from State 11/10/2012 DAltimore, MD Important 4 Donation 5 Other (Specify) VAUGHN GREENE FUNERAL SCUS Signature of Funeral Service Licensee Road. Baltimore, Md. 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending physical for use as the b IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy Day in the past 12 months? Month Year 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifics 26. Place of Death (Check only one) 25. Was case referred to medica **Division of Vital** Be examiner? 2 N 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral o 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Da 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) weeta barencon 31. Date filed (Month, Day, Year) Registrar's Sign State 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2145 ouis. 2012 bu Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Medical **Baltimore City** University of d Center 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Min Country) Month Day Year) Jul 11, 1949 MD 63 214-46-2135 Director 1 **1** M 2 □ F Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director **Baltimore Arbutus** MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21227 U.S.A. 5542 Oakland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 7/30/1969
1 X Yes 2 No
1f Yes, Give 9/10/1969 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No 9/10/1969 Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Repair Man Marien Equipment Repair Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip Cugle **Betty Lou Martin** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5542 Oakland Road Halethorpe, MD 21227 Sharon Ann Lokey Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ⊈ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)
Glen Haven Memorial Park Nov 07, 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Ser e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part 1. Enter the disea shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cosilar artery disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Tobacce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 ☐ No been signed by the s should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrry practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title Nov. Z 2012 101802 who completed cause of death (Item 23a) (Type, Print) 30. Name and ag O

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

NOV 0

2012

7

32. Registrar's Signature

th Greene Street, Baltimore, MD 21201

Matthews

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ NOVEMBER Day 20 Year 9:25 A M CHRISTINE **CLYBURN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S GLENARDEN 3616 TYROL DRIVE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛱 F  $00^{\text{Month}}9^{\text{Day,}}$ F923 NORTH CAROLINA Director 89 578-40-2894 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S GLENARDEN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA 3616 TYROL DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE FEDERAL GOVERNMENT 2YRS other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fish marked o ဂ MARY BLACKWELL WILLIAM GUNN ige 1 and 2 should be nt of Health and Men t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14209 CLAYTON STREET ROCKVILLE, MD 20853 DARLENE CLYBURN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o once. ■ Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify) HARMONY MEM CEMETERY 11/07/2012 LANDOVER, MARYLAND 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MD 20785 K 23a. Part 1. Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Advance Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 JXNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 X No death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending **▲**Natural 5 Pending 2 Accident hours after death neral Director: <sup>β</sup> d filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D20740 NOVEMBER 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

09289

Box (

P.0.

Records,

Division of Vital

GERARD HARRIS MD 106 IRVING ST NW #4200 WASHINGTON, DC Oate filed Marth Pary 1991 19 32. Registrar's genature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Loretta Carbone November 2012 12:40 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woodholme Gardens Pikesville Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 😿 F Months Hours 1/9/1926 214-22-1636 **Director** Yrs 86 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 28a-f 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 5 10g Citizen of What Country?
United States must be Funeral 23a 200 Belmont Forest Ct. #203 21093 of America items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after deal ment of Health and Mental Hygiene. It fam 27 is marked other than "natural", or iter unry or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. 1 Never Married 2 Married β Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Elementary/Seconday (0-12) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Purchasing Agent McCormick Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ John R. Topper Alice L. Schene injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bernard F. Topper/brother 1329 Hillcrest Dr. Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ott November Evans Funeral 1 🔲 Burial 2 Cremation 3 🗆 Removal from State 6, 2012 4 Donation 5 Other (Specify) Forest Hill, Maryland Chapel – Bel Air 21. Sign of Funeral Service Licens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Debilit MOIN Medical resulting in death) Due to (or as a consequence of) Examiner Olomary Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown the a 9 Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? Hospital or Attending Physician; The law page 2 s After this certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 2 No ပ္ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work? within 24 hours after death.

To the Funeral Director. As completed filled in both. death. 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, Division of Vital

State Registrar

31. Date filed (Month, Day, Year egistrar's Signature 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

an (stalls

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0061199

29d. Date signed (Month, Day, Year,

St. Suite 4105, Tauson MD 21204

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Ruth Cavill November 01, 2012 11:20 A.M 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 405 Kilree Road Unit 204 Baltimore County Timonium Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Days Hours 216-42-1435 1 🗆 M 2 🔀 F 69 May 26,1943 Baltimore, MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 Kilree Road 21093 Unit 204 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White If Yes, Give 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Housing Aid Elementary/Secondary (0-12) 12 College (1-4 or 5+) Council Housing Councilor 03 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Thomas Grosscup Lena Loretta Straus 19a. Informant's Name/Relationship (Type, PrintAttorney 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Andrea Gillespie 40 York Road Suite 300 Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name cation - City or Town, State Harford County 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Evars Funeral Chapel and Cremation Services, Inc. Saturday, 4 Donation 5 Other (Specify) Nov. 03, Forest Hill, Maryland of Funeral Service because Jeffrey L.Cair, Sr.CFSP 22 Name and Address of Facility ives Funeral and Cremation Center, P.A. Lic.#M00677 2325 York Read Timenium, Maryland 21093-2215 Signal 1. Enter the disease, or cock, or head failure. List on y applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Live retail 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown 23e. Did tobaccouse contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical **Examiner** Examine

and burial-trai

the attending physician

as the

asn

for

detached

page 2 should peen

director,

funeral

filled in by

has

certificate

certificate be Box 68760

P.O. |

Division of Vital Records,

or Attending s after dea...ral Director: After

Hospital 24 hours

within 2 To the I

Physician/Medical

þ

Completed

Be

မ

Certificate:

Medical

Physician/

Medical

Director

Funeral

ģ

Completed

Be

ည

**Examiner** 

**Funeral** 

Director

notified 28a-f

ō items 23a or ner must be r

er than "natural", or ite the Medical Examiner

n and Mental Hygien ris marked other tl

Health tem 27

27 is marker traumatic

: If item 2 or other

Department of H Important: If ite any injury or oth

permit.

Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

24b. Were autopsy findings available prior to completion of cause of

autopsy perform Yes 2 1

4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

26. Place of Death (Check only one)

death?	2 No	

examiner? 2 NO 27. Manner of Death

25. Was case referred to medical

1 Natural 5 Pending Accident Suicide

28a. Date of injury (Month, Day, Year) Investigation 6 Could not be determined

Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of pertific

31. Date filed (Month, Day, Year)

State Registrar

			Please	Type or Print						_	
			For State	State of Mary				Mental Hy	giene 2	0   2	35536
		_	Registrar  1. Decedent's Name (First, Middle, Lateral	of)	Cei	tificate of	Death		Reg. No.		
	Physicia		David Edward Cle					2. Date of De Month Novembe	_	201 <sup>Year</sup>	3. Time of Death 6:55 p M
1	Medic Examin		4a. Facility Name (if not institution, give			4b. City. Town, o	or Location of Dea			inty of Death	0:33 P
_			619 N. Fountain (			Bel Ai				arford	
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th V Vearl	9. Birth	place (State or Foreign
	Director		213-38-8615	Z 7	3 Yrs.	Working Days	Tiodis Willi	Jan. I	0, 193	9 Mä	ryland
	nd how	5	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	faryla Sa-f s tified	ect	Maryland Harford		Bel Air						1 🗆 Yes 2 🔀 No
	the N	ä	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medic I Examiner must be notified at	Be Completed by Funeral Director	619 N. Fountain	Green Road		2101	5		USA		
	death item ner n	T.	11. Marital Status	12. Was Decedent Ever Armed Forces?		Nas Decedent of F f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White,	
36	after al", or xami	d by	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give		Yes 2 🛮 No	Specify:		Spec		
21215-0036	nours natura icel E	lete	15. Decedent's E	Year or Dates. ducation	16a. Deced	dent's Usual Occup	nation			of Business In	
215	in 72 e. ian "r	dmo	(Specify only highest gr. Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give	kind of work done O NOT use retired	during most of wo	orking	Tob. Ring o	n Dualiteaa iiri	dustry
2	l withi ygiene ner th	ပိ	12		Truc	k Servic	e Techni	cian	Fuel	Suppl	ier
nd	filed tal Hy ed oth	To B	17. Father's Name (First, Middle, Last)					ame (First, Middle,		ame)	
γ	uld be I Men narke natic	_	Ivan Clarence Cl					Ruth Jen			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (7)  Carole Cleary /			ng Address (Street N. Fount					
e)	and Heal tem 2		20a. Method of Disposition		0b. Place of Dispo		l l	Date		on - City or To	
Baltimore,	ent o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, cren Iiqhview	natory or other pla		-6-12			aryland
alti	permit. F Departm Importa any inju		21. Signature of Fundral Service Licente			Name and Addre	es of Facility			2011/ 1	ar j roma
<u>m</u>	8 <b>E E S</b>		1 Couch C	mg/	5	0 W. Bro	uneral H adway, B	ome, P.A el Air,	MD 210	14	
н			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the ne cause on each line.	death. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory an	rest,		Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	2		Liver	cance	V			Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):						
		er	Sequentially list conditions,	b. Due to (or as a con	sections of:						
	ted I nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Dao to (or ac a cor	isequente on.						
	be executed sician and burial-transit	Ex	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):						
8	te be inysicia	Jical		d							
9289	eath certificate b attending physical for use as the b	Med	IF FEMALE:								
ж	th cel ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 Live Birth 2	Fetal death 3		су			Date of delive	-
Вох	the a	Physician/Medic	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 ∟	Other (specify) _				MOTHE	Day Year
P.O.	that the led by t detach		Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
S,	requires the been signed should be a	Completed by						1 🗆 '	Yes 2 N	o 3 🗆 Prot	pably 4 Unknown
oro	av requas beer 2 shou	plet						24a. Was			osy findings available
3ec	The la	mo;						autop perfo	rmed? 2 <b>X</b> No	death?	mpletion of cause of
E	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. P	lace of Death (Che		Z JA NO	1 2 103	2,4110
of Vital Records,	Physic this co	은	I LI Yes 2 LANO		2 ER/Outpatien		4 ☐ Nursing I	lome 5 Resid	lence 6 🗆 C	Other (Specify)	)
n 0	Attending Physician: The law requires that the death certificate be executed at death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transition.	Certificate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injur worl M 1	yat <br  Yes 2. □ño	28d. Describe h	ow injury occ	urred	
Sio	Atten r deat ctor: y the	ij	2 Accident Investigation 3 Suicide 6 Could not b		At home, farm, stre		res Z 🗆 NO	28f. Location (S	itreet and Nur	mber or Bural	Route Number
Division	al or / s after il Dire		4 ☐ Homicide determined	building, etc. (Sp	ecify)	,		City or Tow		noer or ridra	rioute ivanibei,
1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Exami	sician: To the best of my k ner: On the basis of examir	nowledge, death o	occured at the time	e, date and place,	and due to the cau	use(s) and ma	nner as state	d.
0)	To the H within 24 To the Fi complete	ΨĚ	only one) 3 L Certifying Nurs	ner: On the basis of examine Practioner: To the best	of my knowledge, o	leath occurred at th	e time, date and pl	ace, and due to the	e cause(s) and	manner as sta	ise(s) and manner stated. ited.
	5 v vit		29b. Signature and title of certifier	Alm		29c. Licens		_	29d. Date sig	-1	
	1 pm		00 Managari	/ 10/	IVID		0621	10	111	5/2	012
	15 0		30. Name and address of person who of 2533 AUGI	STINE F	(Item 23a) (Type, P にんかみ	N STATE	Y. SUIT	- A PHT	CADEA	KECT	14, MD 21915
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's S	7	- 1,00	() >011	- MICHE	11 6/1	,	THE PERIOD
	Registra	ır	NOV 0 7 2012	Buch	1 bour	J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day NOV. 2 d T 2 4:10 pm Barbara Jean Cramblitt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months N Month, Day, Year 1 946 Marryland 214-44-6194 65 1 □ M 2 🎖 F Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Carroll Hampstead 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 1211 N. Main St. Apt. 206 21074 U.S.A. Items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ō δ 1 Never Married 2 Narried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Is marked other th Receptionist Food Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Donald Cooper Leona May Jerrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 permit. Page 1 end 2 sh Department of Health ar Important: If item 27 Is any Injury or other trau William A. Cramblitt -1211 N. Main St. Apt. 206, Hampstead, MD. husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV • 20a. Method of Disposition Date 6,2012 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory Sykesville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Sinth Eigh 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition week Medical resulting in death) Due to (or as a consequence of) Examiner Week Sequentially list conditions, if any, leading to immediate cause Enter Underl, in Cause (Disease or injury Due to (or as a consequence of): attending physicien and I for use as the burial-transit Exami law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day signed by the a Id be detached 1 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No as been sign 2 should t 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Attending Physicien: The within 24 hours after deeth.

To the Funerel Director, After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospitel or Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, dual his counted at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RIVIVA 3/12 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Allui 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2012 7:05 P<sup>M</sup> Virginia Lee Collins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Howard 8375 Sunset Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Director 219-20-3414 Usual Residence of Decede 1 🗆 M 2 💢 F 85 1927 Virginia Feb 1. or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2X No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 4710 Woodland Road 21043 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes. Give Specify: White 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Spring Grove Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ be Mary Catherine Lunsfurt permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic once. Neal Bledsoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Richards, Daughter 8375 Sunset Drive Ellicott City, Maryland 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/06/12 Baltimore, Maryland Signature of Funeral Service Licenses Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCIEROSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner YE ARS STROKE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by INFECTION TRACT URINARY 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 greatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 038296 NOVEMBER 6, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8186 LARK BROWN RD, SuiTE ZOI, FUCKIBGE, MD 21075 6 1BBOWS, MD JOSEPH 32. Registrar's Sin Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3553 3. Time of Death Decedent's Name (First Middle 1 ast) 2. Date of Death Physician/ Day Willard Dean Caudill 29 2012 Medical October 0 9.20a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre De Grace Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours (Month, Day, Year) Oct. 17, 1946 Director 219-42-6371 1 X M 2 D F 66 Maryland Yrs Usual Residence of Deced 2 should be filed within 72 hours aftar death with the Meryland th and Mantal Hygiane. 27 is merked other then "natural", or items 23a or 28a-f show traumetic event, the Medical Exteriner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Harford Havre De Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 316 Robin Hood Road 21078 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black White etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 <u>Factory Worker/ Welder</u> Manufacturing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Ervin C. Caudill Annie Hart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Robin Hood Road Havre De Grace, Maryland 21078 Mary J. Caudill / wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. Nov. 2, 2012
Baltimore, Maryland 20a. Method of Disposition Paga 1 permit. Paga 1 Department of Importsnt: If it any injury or o 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a Part 1 Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner acute myocamial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): eata hes baan signed by the attanding physician and pega 2 should ba deteched for use as tha burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by coronary artery disease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital tha funarai diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO 욛 1 Inpatient 2 ER/Outpatient 3 I DOA 5 To the Hoapital or Attending Ph within 24 hours after daeth. To the Funerel Director: After thi completaly filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Centrying Newse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and little of certifier 29c. Ricense number 2223 29d. Date signed (Month, Day, Year) 10/31/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fermin Barneto, Ir MD SUD LARER Chesapeak Drive Bei HIV MD 21014

DHMH 17 Rev 06-2011

State Registrar 32. Registre s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 201<sup>°</sup>2° Barbara Jean Cohen 5:40 p м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** reb 26, 1961 Months Days Hours Min. New York **Director** 072-56-4209 Usual Residence of Dece 1 ☐ M 2 😾 F 51 23a or 28a-f show 10a. State 10b. Count within 72 hours efter death with the Maryland event, the Wedical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🗔 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1730 Chiswick Court 20904 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 2002–2012 Black, White, etc. 1 Never Married 2 Married "natural", or <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ <u>Pharmacist</u> US Government permit. Pege 1 and 2 should be filed wil Depertment of Heelth and Mental Hygie Important: If item 27 is marked other eny injury or other traumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Morris Kimmelman Doris Glazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Franklin Cohen/husband 1730 Chiswick Court Silver Spring, MD 20904 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/03/12 Woodbine, MD 21. Signature of Funeral Name and Address of Facility
Soing Home Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, Beverly L. MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Metastatic Anal Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of) or Attending Physician: The law requires that the death certificete be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Tes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Dother (Specify) hospice this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital To the Hospital within 24 hours To the Funeral Completely filled Medical 29a, Certifier 1 Cacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Bindu Joseph, M.D.

NOV 0 7 2012

31. Date filed (Month, Day, Year)

D60634

6001 Muncaster Mill Rd. Rockville, MD 20855

November 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 3:56 Рм Beverly Mary Concaugh Medical 4a, Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Health And Rehab Bethesda 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth Funeral (Month Pay Year) 34 Days Min 1 M 2 X F New Hampshire 025-26-1145 78 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 23a or 28a-f 1 Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20814 USA and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed White Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John Kerrigan Mina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Joseph M. Concaugh, Jr. / Son 1602 Auburn Ave., Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 11/6/2012 4 Donation 5 Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury pue to for as a consequence of: or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) detached a | Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes plnods Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗆 Yes မ 4 Aursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury n 24 hours after death.

e Funeral Director: After the function of the functin 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funei

completed fii 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Swin D 30057124

Registrar

DHMH 17 Rev 7/2009

State

Udecular Drive # 206, Rochille,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

7 2012

BAO

O VON

31. Date filed (Month

10110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 05 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ba Hmore If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year! Director 1 M 2 F Yrs Usual Residence of Decedent 10b. County 10d. Incide City Limits or 28e-f sho 10c. City, Town or Location traumetic event, the Madical Examiner must be notified at Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 82 Funeral 23e or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No and Mental Hyglene. Is marked other than "natural", Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) ister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 permit. Page 1 and 2 sh Department of Heelth ar Importent: If Item 27 Is any Injury or other trau once. # = 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify), 21. Signature of Funeral Service Licen 5 23a. Par 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): eate hes been signed by the ettending physician and pege 2 should be detached for use es the burlal-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicis completely filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 34b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to ical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be determined Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) fonth. Day State Registrar

Ernest Convay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 01 2012 HARTWOOD CORNELL JR Medical 08:08AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 213-24-7716 1 🛛 M 2 🗆 F Usual Residence of Decedent Jun. 22, 1928 Maryland i item 27 is marked other than "natural", or items 23e or 28a-f show other treumetic event, the Medical Examinar must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Walkersville 1 🛮 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 59 W. Frederick St. 21793 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) was becedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1951—58 14. Race - American Indian, 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 owner/operator gas station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hartwood Cornell Sr. Elsie May Kinsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Cornell/ wife 59 W. Frederick St. Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Mem. Gard. 11/5/2012 Frederick, MD 21. Signature of Fulneral Service Lice 22. Name and Address of Facility Hartzler Funeral Home, P.A. amarine 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final disease or condition rval Between Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury Immunosy that initiated events resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Myocardial 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760 erel Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac within 24 hours a
To the Funerel D
completely filled

should be filed within 72 hours efter death on Mental Hygiene.

f Health

permit, Page 1 e Department of H Important: if Ite any injury or ot

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marries Nillia - Fractice tredrick Mumorial 32. Registrar's Signature

400 W. 7th St.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day November Year Physician/ 1231 DANIEL EDWARD CROGAN 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) (Month, Day, **Funeral** Days Min. 1 X M 2 🗆 F Macyland Director 83 **219-22-9348** Usual Residence of Decedent Important of Health and Mental Hygiene. Important if it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Baltimore City N/A 1 X Yes 2 ☐ No Macyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21212 5628 Alhambra Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No WWIII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Roads Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Noca Barcett Edward Joseph Crogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Ravens Nest Court, Glen Aon, Maryland 21057 <u>James X. Crogan, Jr. (Nephew)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dul. Valley Men Grdns 11/5/2012 Timonium, Maryland 21. Signature of Funeral Service TCHECK-VIEWEFELD FUNERAL HOME, INC. 00 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final liver tailure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate outset. E. tel outset/ling. Cause (Disease or iinjury Due to ( r as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transi To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? After this certificate has funeral director, page 2 1 Yes 2 No within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗹 No ပ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

6

CROGAN

FOWARD

5601 Lock Raven Blvd Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TH+anl Pittman
31. Date filed (Month, Day, Year)

NOV 0 7 2012

RES 000

November 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a&c Per FH G933 11/0/11/2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar 35545 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ nhenia INS 06:27 AM 2012 actobe, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HODDITA NIA Memoria H More nior Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Unk Months (Month, Day, Year, Country) Montreal 1 🗆 M 2 🗹 F Director 94Yrs 1918 uelvec me 10a. State Que permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturo" any injury or other treumatic events. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Montreal 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral LSA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19a. Informant's Name/Relationship (Type, Print) a Himore ollins ata 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State ry, crematory 1 Surial 2 Cremation 3 Removal from State Monteral 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility berty 4600 Heights art 1. Enter the disease, or complications that cus the death. Do not enter the mode of dying, such as or rdiac or respir fory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prieumonia disease or condition MENTH Medical resulting in death) Due to (or as a consequence of) Examiner nutrition Months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons vuence of). burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Dementro Severe rears that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending physic for use as the b Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 1 Yes 2 No eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury after death. Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical within 24 hou To the Funer completely fil 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, MD october 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 EUNIVERSITY Miller itospital MD Union Memoral Stauntor auva Itimere 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar MDHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	State of Maryland / Depart	artment of Health and N	Mental Hygiene	o offile
		_	State Registrar	Cer	tificate of Death	Reg. No. 20	2 35546
	Physicia Medic		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day 3 Yea	3. Time of Death
	Examin		4a. Facility Name (if not institution, give stre	et and number)	8alhmore	4c. County of De Balton	nore City
	Funeral Director		5. Social Security Number 6. Sex 1 -	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 9. E (Month, Day, Year) 195	Birthplace (State or Foreign Country)
	rland f show d at	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo			10d. Inside City Limits
	the Mary or 28a-	Director	10e. Street and Number		10f. Zip Code	10g. Citizen of What	1 Pres 2 No
	ath with ms 23a must b	Funeral	3505 Greenn  11. Marital Status 12		Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	nerican Indian,
9036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ ✓ Specify:	Rican, etc.) Black, Wi	
Maryland 21215-0036	nin 72 hou ne. <b>than "natı</b> <b>e Medica</b>	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16b. Kind of Busines	ss Industry
nd 21	filed within 72 tal Hygiene. d other than ' event, the Me	a)	17. Father's Name (First, Middle, Last)	Cook	-	ne (First, Middle, Maiden Sumame)	Ham
laryla	should be fill and Mental is marked ( aumatic eve	- 10	19a. Informant's Name/Relationship (Type		ng Address (Street and Number or Rura	al Route Number, City or Town, State,	Zip Code)
re, N	1 and 2 s of Health item 27 other tra		Wayne Cart 20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 20c. Location - City	or Town, State
Baltimore,	permit. Page 1 a Department of F Important: If it any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signat ☐ Funeral Service Lice 1988	Metro		5/2012 Bath	more, M
Ba	permi Depar Impor any ir	- 12	Klien K. Y.	well Al. 3	331 Blenms	Lu, Baltin	and the
	Physician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one of Immediate Cause (Final disease or condition	ations that caused the death. Do not entrause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
المعديدة	Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate caucate that on activity grays (Disease or linjury	Due to (or as a consequence of):			
	icate be executed g physician and s the burial-transit	al Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
68760	tificate b ng physi as the b	Medical	d.				
Вох	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown		Ectopic pregnancy Other (specify)	23d. Date of Month	delivery Day Year
, P.O.	es that the	ρ	Part II. Other significant conditions conti	ibuting to death but not resulting in the (	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?  Probably 4 Unknown
cords	aw require as been si 2 should	Completed				24a. Was an autopsy 24b. Were prior	autopsy findings available to completion of cause of
l Rec	n: The la ficate har, pr, page	e Com	25. Was case referred to medical		26. Place of Death (Chec	performed? death	Yes 2 No
Vita	ysicia is certi directo	To Be	eveminer?	spital: 1 Inpatient 2 I ER/Outpatie	Other:	ome 5 Residence 6 Other (Sp	pecify)
n of	nding Ph tth. : After th e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time o injury	f 28c. Injury at work?  M 1  Yes 2  No	28d. Describe how injury occurred	
Division of Vital Records,	l or Atter after des Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examine	an: To the best of my knowledge, death On the basis of examination and/or invest Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	at the time, date and place, and due to t	ne cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 L Certifying Nurse   29b. Signature and titled certifying Nurse	Out and a Change	29c. License number	29d. Date signed (Mo	
U	)		4:	plete cause of death (Item 23a) (Type,	Print).	11	91222
	Sta	to	Alexandra . K. wa. 31. Date filed (Month, Day, Yar), 20	132 Registrar's Signatur	ul Place, bo	Homore, MO	S ISOS
	ાત Registr		NOV U 7 201	Deserr B. A.	arker		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ .30AM 2017 Medical 4c. County of Death Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Howar blumbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Month, Day, Country) 65 Yrs. Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Nes 2 No ton 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 √ Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No ack Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Broke Be Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last, ပ Duis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Informant's Name/Relationship (Type, Print) 704 resimand 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ouns ville 4 Donation 5 Other (Specify) Sign of Funeral Service Lice 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Plu ician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Veat 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 NER/Outpatient 3 IDOA 잍 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: **□** Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ORt 31 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_awrence Crawto		S 1- For State Registrar	tate of Marylar		artment o rtificate o		nd Mental I		201 eg. No.	2 30040
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year								
Medical Examin		4a. Facility Name (if not institution				4b. City, Town,	or Location of Dea		4c. County of De	0544 hrs
_		Peninsula Regional M				Salisbury			Wicomico	
Funeral Director	5. Social Security Number 216–96–0589	. Age (In yrs. I		Months Da		lrs. 8. Date of Birlin. 02/27/		Birthplace (State or reign Country) MD		
au à	ŀ	Usual Residence of Decedent  10a. State  10b. County		10c. City,	Town or Locat	ion		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
<b>*</b>	5	MD n/a			Bal	timore			1 XYes 2 No	
Maryli r 28a-f	Director	10e. Street and Number				10f. Zip Code		10	Og. Citizen of What C	country?
with the Maryland is 23a or 28a-f sho	를	2906 Ridgewood	12. Was Deced	dent Ever in U.	S. 13. Wa	212		Specify Yes or No-	USA - 14. Race - Ar	nerican Indian, Black,
death w	Funeral	1 X Never Married 2 N					an, Mexican, Pue		White, etc	<b>.</b>
safter or ral", o	J F		vorced If Yes, Give Year or Dates:			Yes 2X		Consideration of	Specify: BI	
2 hours	g.	15. Decedent's Education (Spe Elementary/Secondary (0-12)					pation (Give kind o ife. DO NOT use r		166. Kind of Busine	ss/industry
5-0036 led within 72 hours af Hygien 72 hours af other than "natural the Medical Examin	Completed	11			Bake	r & Dec			Gourmet	Bakery
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be င	17. Father's Name (First, Middle Lawrence Edwar		Sr				ne (First, Middle, N	Maiden Surname) Nia James	
212 ould be i Menta s mark	밁	19a. Informant's Name/Relations	ship (Type, Print )	DI.	19b. Mailin	g Address (Str			aber, City or Town, Si	ate, Zip Code)
MD and 2 sh alth and 27 in a 2		Katherine Hall  20a. Method of Disposition	_ / Mother	Lage		Ridgewood		altimore,	MD 21215	
Ore, ges l a t of He : If ite		1 X Burial 2 Cremation	n 3 Removal from	n State	crematory or ot	her place)				
iltim iit. Pag artment ortuntt ry or o	k	4 Donation 5 Other S 2 Signature of Farteral Service		Kir	ng Memo	rial Pa: Name and Addre	rk 111 ess of Facility	.9.2012	Windsor M Directors,	ill,MD
Dep Dem		23 Part I. Enter the disease, o	1		Jol 45	nn L. Wi 17 Park	illiams I Hahts Av	Funeral D ze Baltin	ore. MD 2	<u>1215                                   </u>
Physician		23a Part I. Enter the disease, o failure. List only one cause	r complications that cau on each line.	sed the death	. Do not enter t	he mode of dyin	ig, súch as cardiad	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
examiner	1	Immediate Cause (Final disease or condition resulting in death)	e a. Asthma Due to (or as a c	onsequence o	f):					Death
		Sequentially list conditions, b								
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence o	f):					
ed sait	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	f):					
O,  be executed  rsician and burial - transit	edical	X UNPENDED	d.  X AMENDED#1	,23a,2	7,per	ne,g935	1-25-13	sm		
760, cate be exphysiciar	₩.	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, ou						23d. Date of deli	
Box 6876 death certificate the attending phy defor use as the b	cian	past 12 months?	I FIAG DILL	h nt at time of de	oth -	tal death 3 her (Specify)	Ectopic preg	nancy	Month	Day Year
BO he death	Physician/N		9 Unknow				a since in Book (	I 220 Did to	bacca usa cantributa	to the cause of death?
P.C.	≦	Part II. Other significant condi	tions contributing to d	leath but not r	esuiting in the t	inderlying cause	e given in Fart i.			Probably 4 V Unknown
rds, require been si	Completed							24a. Was a		autopsy findings available to completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death.  a) Director: After this certificate has been sided in by the funeral director, page 2 should be a fine or the funeral director.	m o							perfor	med? death	1?
ion: T	Be C	25. Was case referred to medica examiner?	100				ce of Death (Chec			
Physic Physic er this	의	1 Yes 2 No 27. Manner of Death			ER/Outpatient		Other <sub>4</sub> Nurs		Residence 6 0	ther:
ion of tending Ph eath.  tor: After the funeral	Ë	1 X Natural 5 Pen	28a. Date of (Month, D	ay,Year)		· · · · · · · · · · · · · · · · · · ·	Yes 2 No			
ViSion Attender Directo	Certification:		estigation 28e. Place	of Injury - At he	I ome, farm, stre	et, factory, office	e building, etc.	28f. Location (S or Town, S		Rural Route Number, City
Ospital hours a numeral by filled	5	4 Homicide	ermined (Specify)	T						
To the Howithin 24 F	Medical	(Check only	Physician: To the best of aminer: On the basis of	examination a	_					
To with To con	Me	29b. Signature and title of certifi	and manner state	Δ.			nse number		29d. Date signed (	
		m	M	) \		0.0	C.M.E.		November 2, 2	2012
		30. Name and address of person Russell Alexander MI				W. Baltimor	re Street, Balt	imore, MD 212	223	
Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Signatu	ure .		,			
Registr	ar	NOV 0 5 20	12 Brown	1 2.	barke			OCASE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35549 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27, 2012 October 9:57 Рм Pamela Sue Davies Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Healthcare - The Pines Talbot Easton 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min. (Month, Day, Year) 01/04/1960 Country) Kansas Director 220-78-9671 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Talbot Royal Oaks 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21662 6831 Bellevue Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event \*\*\*\*. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Arts & Crafts Salesperson 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Price John C. Davies Judv Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6072 Laurel Grove Road, Denton, MD 21629 Edmond Caron / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 11/05/2012 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Gas and Death Immediate Cause (Final Physician/ reast disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ilure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 20 I or Attending Physician: after death. Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Tes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 610

Dutchmarks Lane

ause of death (Item 23a) (Type, Pri<del>nt)</del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23:00 M Josephine DidGe U 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University Baltimore Maryland Medical If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 07 05 Hours Min **Director** 240-34-1716
Usual Residence of Decedent 1 ☐ M 2 🟋 F 84 NC items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Millington 21223 U.S.A. Ave Apt filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates Yes 2X No Specify Completed 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6th grade na Sewing Factory Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F Sally Bulter McKinley Marsh ge 1 and 2 should but of Health and Mer: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Emma J. Dickey-Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Shire Lane, York, PA 17406 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If i any injury or conce. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 11/10/2012 Baltimore, Md anature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md Pay 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Coronary arteru disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical as the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Por in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year the detached 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 124 hours after death.
• Funeral Director: After this certificate has b. performed Yes 2 2 🗆 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 💢 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗆 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certification 29d. Date signed (Month, Day, Year, D0073872 11/01/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar altimure

Room

32. Registrar's Signature

Greene

NOVO

31. Date filed (Month, Day, Year)

NIZW4

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Erwin Daniels 1- For State Certificate of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 3, 2012 0336 hrs DANIELS, JR Medical Examiner ERWIN NAPOLEON 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Raltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 218-98-3025 1 X M 2 F 30 Country) MD 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Baltimore MD Director 10e. Street and Number 10g. Citizen of What Country? 618 N. Lakewood USA 21205 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, "natural", nr items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes Specify: Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene. Youth Mentor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Latrice Johnson N. DANIELS Erwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowland Avenue · Baltimore, Md. 21206 Jonathan Daniels Uncle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 MT Zion Cemetery 11-8-12 4 Donation 5 Other Specify 22. Name and Address of Facility VAUGHN GREENE FUNERAL SEVS York Road. Bultimore, MD. 21212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical a. Gunshot wounds (2) of torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Day 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical 8 Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Nov 3, 2012 Subject shot Natural 1 Yes 2 ✓ No Pending within 24 hours after death.

To the Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide or Town, State) 600 North Lakewood Avenue, Baltimore, Md. (Specify) Townhouse / Rowhouse 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E November 3, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November Physician/ DeShazo 3:054 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Haspice Towson Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral . 59 Director 1 🗆 M 2 💢 F 29 1918 0 permit. Pege 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mentel Hyglene. Importent: if item 27 is marked other then "neturel", or itsms 23e or 28s-f show eny injury or other traumatic event, the Medical Examiner must be notified at engited. 10b. County **Funeral Director** 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 XNo 10g. Citizen of What Country? 14 Lomond Court 21237 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black 3 X Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th grade N omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Will Inin ()della 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Bergene Daughter De Snazo 16 Lamond Court 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/14/2012 4 Donation 5 Other (Specify) Garnson Chinas Mills, MD 22. Name and Address of Facility augm C. Greene Funeral Service 21. Signature of Funeral Service Licenses 8728 Liberty Road Randalktown MD 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Physician disease or condition minis Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease of injury that initiated events Examiner Due to (or as a consequence of): attending physicien end I for use es the burief-transit To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown .... After this certificete has been si funeral director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Å Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funerel D
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 2012 address of person who completed cause of death (Item 23a) (Type, Print) Tavson MO 31. Date filed (Month, Day 32. Registrar's Sig NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2012 5:56 PM October Alonzo K. Douglas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days (Month, Day, Year) Hours Director 579-94-3409 1 🕅 M 2 🗆 F 50 Yrs 1962 July 12, Maryland Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1X Yes 2 □ No Prince George's Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3849 St. 20746 USA Barnabas Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Completed by Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 10yrs Food Services other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rufus Tucker Carol Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3526 Maywood Lane #2 Suitland, MD 20746 Kelvin O. Douglas/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2012 Lothian, Maryland Moses Cemetery 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7474 Landover Road Hyattsville, MD Part 1. En/er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, to heart fature. List only one cause on ear h line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No ER/Outpatient 3 DOA 1 Inpatient 2 X မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 - Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely

State Registrar

3 🗍 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 2012 12:06 Morton Diamond РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4119 Crosswick Turn Bowie 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 110-24-5863 Director 80 1 M 2 □ F 5-7-1932 New York or then "natural", or items 23a or 28a-f show the Modical Examiner must be rotified at 10a. State 10b. County with the Meryland 10c, City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4119 Crosswick Turn 20715 United States within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? 195
1 🖾 Yes 2 🗆 No
If Yes, Give 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1953 Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1955 1 ☐ Yes 2 ☒ No Specify: Completed 3 Widowed 4 Divorced WHite Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Deputy Director Adolescent Group Home Be permit. Page 1 end 2 should be flied Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other traumetic event 9DEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abraham I Diamond Shirley Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Diamond - Wife 4119 Crosswick Turn, Bowie, Maryland 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 11-6-2012 Adelphi, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels <del>Br</del>ad Smetzer 1170 Rockville Pike, Rockville, Maryland 2D852 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List offly one cause on each line pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Graet and Death Physician/ Carcinama disease or condition resulting in death) STURMOUS Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day 2 No sate has been signed by the spege 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 2 / **Division of Vital** the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 No မှု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a the Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012

State Registrar 30. Name and address of

V Crich A.

31 Date filed (Month, Day, Year)

NOV 0

DHMH 17 Rev 06-2011

NY) ƏLYOL

ise of death (Item 23a) (Type, Py

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 5 Norma Lillian DeBoard 2012 1:50a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Harford Forest Hill Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours **Director** 411-54-6394 77 1 M 2 X F 10/31/1935 Tennessee or 28a-f shov 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Mactical Experience must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Woodland Green Way 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 YOVEMBER 5,2017 1 Yes 2 XNo Specify: white Completed 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government 12 Civil Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John T. Broyles Wilsie Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Kaigler (daughter) 213 Woodland Green Way, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 e Department of H important: if ite any Injury or ot Date 13 ☐ Removal from State cemetery, crematory or other place) Baker Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/08/2012 Aberdeen, Maryland 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury ettending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown erai Director. After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No Yes Division of Vital Hospital or Attending Physician: B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 X No 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury death. Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours e To the Funeral Completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title ed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35556 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Michael William DePalma 0930 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 3148 Gracefield Road #CL-514 Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** (Month, Day, Ye ov 28, Days Hours New York Min. Director Nov 1 □ M 2 □ F 057-14-5154 92 Usual Residence of Deceder 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No Silver Spring MD Montgomery è 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral USA 20904 3148 Gracefield Road #CL-514 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1942–79 Black White, etc. "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify. Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Public High School 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maria Cataldo Joseph DePalma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Whitingham Drive Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Janet Roddy/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Final Journey Cramatory 11/07/12 1 D Burial 2 D Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 6 Sing Home Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, MD 21029 Beverly L. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the Immediate Cause (Final Pnysician/ disease or condition Cerebrovascular Diseasc Medical resulting in death) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Dementia attending physician and I for use es the burial-transi that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No sate has been signed by the atter page 2 should be detached for a Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 • Hospital or Attending Physicien: The law requires t 24 hours after death. • Funerel Director: After this certificate has heen sim 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an performed? Yes 2 XNo 1 🗌 Yes 2 🗎 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 X No မှု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier The defining Projection in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

1571

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 0.7

Loveen J. Puthumana,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

rack

29c. License number

3110 Gracefield Road Silver Spring, MD 20904

D59524

29d. Date signed (Month, Day, Year, November 5, 2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3ty, 2012 4:00 рм Vashni Simanovich DePaz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12304 Stoney Bottom Road Germantown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) Director 1 □ M 2 🖳 F 186-68-7797
Usual Residence of Deced July 31, 1973 39 Pennsylvania Yrs ed other than "natural", or items 23e or 28a-f shove event, the Medical Examiner must be motified at the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 12304 Stoney Bottom Road 20874 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If tem 27 is marked other the eny injury or other treumatic event, the 1 000. Business Analyst Health Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ronald John Simanovich Donna K. Pollock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberto DePaz/husband 12304 Stoney Bottom Rd. Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place) 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/03/12 Woodbine, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service Beverly L. MO1251 Heckrotte, P.A. Clarksville. 21029 MD 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): ettending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been sign Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending work?
1 Yes 2 No Director: A d in by the f Investigation within 24 hours after dea To the Funeral Director completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 2, 2012 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Rakesh Malik, M.D.

31. Date filed (Month, Day, Year)

NOV 0 7 2012

Barri

32. Registrar's Signature

19785 Crystal Rock Dr. #209 Germantown, MD 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day, 2012 Physician/ 8:00 PM Randy Allen Driver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard 16835 Hardy Road Mt. Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Min. 216-66-1325 58 Director 1X M 2 □ F Oct 10, 1954 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. sont: If Item 27 is merked other then "neture!", or Items 23e or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Mt. Airv Howard 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 16835 Hardy Road 21771 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates id Mental Hygiene.
merked other then "netur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Water & Sewer Inspector Municipality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Elizabeth Mayne Charles Denton Driver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16835 Hardy Road Mt. Airy, MD 21771 Cynthia Kay Driver/wife permit. Page 1 and 2 Department of Healt Importent: If Item 2 eny Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 11/06/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. 1 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NOUTS Immediate Cause (Final Physician/ a Myocardial Ischemia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer months Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transli that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 🗆 Yes 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV. 5, 2012 A.Z. HEGAZI D44164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.Z. Hegazi, M.D. 46B Thomas Johnson Dr. Frederick, MD 21702 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stephanie Duni	hur	nt State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar  Certificate of Death Reg. No. 2012 3555
Physic Medical Exam		
		4a. Facility Name (if not institution, give street and number)  Northwest Hospital  4b. City, Town, or Location of Death  Randallstown  4c. County of Death  Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1
daryland 28a-f show any 1 at once.	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 ☒No.
ath with the Maryland items 23a or 28a-f sho ist be notified at once.	Director	10e. Street and Number  4342 Meadow Mills Road  10f. Zip Code  21117  10g. Citizen of What Country?  USA
fter de	by Funeral	3 Wildowed 4 Divorced If res. Give rear 1 Yes 2 No specify: Specify: Specify:
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examir	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	
21215-0036 21215-0036 Jud be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be Completed	Charles Brown Ethel Sconion
- p = 1 = 1	To	Rarl K. Munt / MUSDand 14342 Meadow Mills Road Uning Mills MD 21117
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  Anatomy Gifts Registry  20b. Place of Disposition (Name of cemetery, crematory or other place)  Anatomy Gifts Registry  21 Name and Address of Facility  Anatomy Cifts Registry
		7522 Connelley Dr., Ste. P, Hanover, MD 21076
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hemopericardium  Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Bequentially list conditions,  Due to (or as a consequence of):  Buptured Aortic Dissection
ed	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):
<b>0,</b> be executed sician and ourial - transit	edical	UNPENDED X AMENDED #1 as noted, per me, g934 12-6-12 sm
6876 certificate nding phy	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year  4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. Boys s that the death gned by the att	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
cords, law requires has been sig	Completed t	1 Yes 2 No 3 Probably 4 ✔ Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
tal Rection: The certificate ector, page	Be Con	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
of Vita Physici er this ce	TO B	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA  Other4 Nursing Home 5 Residence 6 Other:  27. Manner of Death
tion of Viteraling Phydeath.  ctor: After ti	ation	1 ✓ Natural 5 Pending 2 Accident Investigation (Month, Day, Year)  1 Yes 2 No
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hos within 24 h To the Fur	Medical	Check only  Check only  Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F × F 3	W	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  November 3, 2012
(4)		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 28a, d-f per me g937 3-22-13 vt. State of Maryland Department of Legible AMEND LINE 28E, PER ME, 6938, 14-9-2013, CDF 35560 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-5-2012 1:40 Αм Medical Angela A. Dacre 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 213-14-4112 1 □ M 2 😾 F Yrs. MD 1-12-1920 92 28e-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mentel Hyglene. Sent: If the elth and Mentel Hyglene. Sent: If the elth as 23e or 28e-f sho sent: If the Maryland Promise and Its morthled should be not other treumatic event, Its Marical Examinations must be notified at jury or other treumatic event, Its Marical Examinations. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3121 Liberty Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Wo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Pietro Ragenese Francesca Mesenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granddaughter 6520 North Point Road Edgemere , MD 21219 Christina Moran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of importent: if it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Redemer 11-8-2012 Baltimore, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, PA 7110 Sollers Point Road Dundalk, MD 21222 M01176 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fracture MD disease or condition Au! Medical resulting in death) Due to (or as a consequence of): Examiner rsumed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use es the burlet-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by con rethre heart 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 DrNe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Other (Specify) W ) p. ( ည 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred probable fall 1 Natural
2 Accident
3 Suicide
4 Homicide fd (Month, Day, Year) 5 Pending 4N/4 OWN 1 ☐ Yes 2 🕅 No Investigation November (, 2012 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office
GRANDAUGHTER Splaughter's home 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fd came determined Edgemere M d 20 Normpoint RD. THOME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 November 5 Zuiz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annen 1 MO 6701 A Charles 55 ms 21204 UHARLES Towso~ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Manchester 3101 Ferrier Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days (Month, Day, Year) Country) 213-92-5710 **Director** 1 □ M 2 🛣 F 53 28, 1958 Maryland Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Manchester Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21102 U.S.A. 3101 Ferrier Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n/a 0 never worked Be filed 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Doris M. Strawsburg Charles Samuel Diehl Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MAnchester, MD 21102 3101 Ferrier Rd. Doris M. Diehl/ mother Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Luth. Church Cem. 10/29/2012 Manchester, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral 21. Sign up of Fyneral Service Licen Home, P.A. Matharin New Windsor, MD 21776 310 Church St. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End - Stage Demuntia Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box ( 3 T Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) signed by the a ld be detached for Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 N 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should 1

Medical 29b. Signature and title of certifier

MSRajapatheMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Rayapa KseMD

Smith AV 5203 Baltimore 2835

State Registrar

29a. Certifier

31. Date filed (Month, Day, Year) 2. Registrar's Signature NOV O 7

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0057465

29c. License number

29d. Date signed (Month, Day, Year)

10/25/12

21209

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 DYSON ALICE October 7:50 p<sup>M</sup> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FUTURE CARE HOMEWOOD BALTIMORE N/A Social Security Number If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs Months Days Hours 1 □ M 2XX 220-30-5333 80 JUL. 25 1932 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 DRUID LAKE DR. APT 312 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1XXNever Married 2 Married 1 ☐ Yes 2 X No Specify Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NURSE 12th grade HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH DYSON LUCILLE DYSON NEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bradford/Nephew Paca St., Baltimore, Md., 21230 2615 S.

11

06-12

20c. Location - City or Town, State

MADSET AND

DATEMODE

Department Important: If any injury or once. Ph. sici.n Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

မ

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1525

32. Registrar's Signature

PO

4 Donation 5 Other (Specify)

**Examiner** 

**Funeral** 

**Director** 

28a-f show

items 23a or 28a-f sho ner must be notified at

ö

"natural",

al Hygiene.

of Health and Mental Hygitem 27 is marked other other traumatic event,

ō

ge 1 and 2 should be fil nt of Health and Mental t: If item 27 is marked

Page 1

the Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner

Completed by

Medical Certificate: To Be

Raymond

31. Date filed (Month, Day, Year)

Miller

and attending physician ours after death. eral Director: After this certificate has filled in by the funeral director, page 2: To the Hospital or Attending Physician: within 24 hours a

Division of Vital Records, P.O. Box 68760

TEL BOTTALION OF OUT OF COPON	" MEIRU C	KEMAIUKI	11-00-12	DALITHURE	MARILAND
21. Signature of Suneral Service Leen		WILLIAM C BR 1206 W. NORT	OWN COMMUNIT H AVENUE	Y FUNERAL HO	OME P.A.
23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the deam. Do not ene cause on each line.  a	, ,	h as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		, 23d. Date of d	elivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause given in		tobacco use contribute t	Probably 4 Unknown
			pe	topsy prior to rformed? prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?		26. Place of	Death (Check only one)		
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other:	XNursing Home 5 ☐ Re	sidence 6 Other/Spe	cifv)
27. Manner of Death  1. Natural 5 Pending 2 Accident Investigatio		of 28c. Injury at	28d. Describe	e how injury occurred	
3 Suicide 6 Could not be 4 Homicide determined		street, factory, office		(Street and Number or Roown, State)	ural Route Number,
(Check 2 Medical Exam	sician: To the best of my knowledge, dea iner: On the basis of examination and/or inv se Practitioner: To the best of my knowled	restigation, in my opinion, dea	ath occurred at the time, date	e and place, and due to the	cause(s) and manner stated
29b. Signature and title of certifier		29c. License num	ber	29d. Date signed (Mon	th, Day, Year)
Raymon Mill	MD	0 0768	3	11/2/12	

Mills MD 21117

20b. Place of Disposition (Name of cemetery, crematory or other place)

METERO CREMATIONS

DHMH 17 Rev 06-2011

State Registrar DWINGS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item 26 per doc g933 II-7-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month October 2012<sup>Year</sup> John Richard Erickson 6:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dakota Broad Creek Assisted Living Harford Whiteford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) Director 288-16-3719 1 ₹ M 2 TF 89 Yrs. July 24, 1923 Chicago, Illimois Usual Residence of Decedent item 27 is merked other then "natural", or itema 23a or 28a-f ahow other traumetic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4700 Water Park Drive Unit K 21017 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No WWIII
If Yes, Give Black, White, etc. ۾ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 DWidowed 4 Divorced Completed & Korrean Year or Dates. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is merked other then any injury or other traumetic event, the Ma College (1-4 or 5+) Elementary/Secondary (0-12) Mechanical Engineer 5+ Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Emil Erickson Marcaretta Mattsson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bernice Erickson (Socuse) 4700 Water Park Drive Unit K, Belcamp, Maryland 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel

Pal Air 20c. Location - City or Town, State November 01, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Forest Hill, Maryland Funeral Service Licensee Toffrey R. (M01543) 21. Signature of 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — 1 3 Newport Drive, Forest Hill, Maryland 21050 Testerman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementra disease or condition resulting in death) vean Medical Due to (or as a consequence of): Examiner KIMSONS years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ending physician and use as the burlel- ransit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> bleeding Division of Vital Records, Completed 1 ☐ Yes 2 ĀNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/9 ☐ Yes 2 AN 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 6 Residence 6 R Other (Specify, 1 ☐ Yes 2 🎗 No assisted |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death living Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accident 3 Suicide work? 1 🗌 Yes 2 🗆 No 5 Pending injury the 1 Investigation Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital of 24 hours at Funeral D Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103 Bata Blvd. -RESET Bel Camp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 Registrar

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Plea									III Copies Iental Hyg			jible.		
	•	State Registrar					Cei	tificate	of D	eath		1	Reg. N	.20	112	3556	54
Physicia	n/	Month Day Year									3. Time of Death						
Medic	al	Ruth 4a. Facility Name (if	) M			70		45 00 3			of Dooth	Novemb			2012	1 5:4Z A	M
Examin	er	250 Gler		_	ia namber)			4b. City, 1	own, or i		or Death		40		of Death	undel	
Funeral		5. Social Security Nu		6. Sex		ge (In yrs. la	ast birthday)	If Under Months		If Under Hours	24 Hrs.	8. Date of Birt		23111	9. Birt	hplace (State or Fore	ign
Director		217-14-2708 Usual Residence of Decedent				10 Yrs.	WIGHTIS	Duyo	110010	1	(Month, Day, Year) 02/18/1922			Ma	ryland		
and show lat	'n	10a. State	10b. County			10c. City	y, Town or Lo	cation								10d. Inside City Limi	iits
Maryl 28a-f otifiec	irect	MD Anne Arundel Pasadena												1 🗌 Yes 2 🛚	No		
th the 3a or t be n	Funeral Director	10e. Street and Number											What Co	untry?			
ath wi	nuel	250 Glet	nwood		s Decedent	Ever in U.S	3. 13.		L122 ent of His	panic Or	igin? (Spe	ecify Yes or No-		U.S.		ican Indian,	
or ite	by F	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No				)		f Yes, speci	fy Cuban	, Mexica	n, Puerto				ck, White		
ursaf tural", al Exa		3 🔀 Widowed		Yea	es, Give r or Dates.			1 ☐ Yes 2			•			Specify	V	White	
72 ho n "nat	Completed		cify only high	nt's Education est grade comp			(Give	dent's Usua kind of worl O NOT use	done du		t of worki	in <i>g</i>	16b. I	Kind of B	lusiness I	ndustry	
within giene. er tha the N		Elementary/Second 12	_	Coll	ege (1-4 or	5+)		ching		ista	nt			Educ	catio	on	
filed vial Hyg	b Be	17. Father's Name (F	First, Middle,	Last)				_		18. Moth	er's Name	e (First, Middle,	Maiden	Surnam	e)		
uld be I Meni narke natic	2	George	Milt		ghes					Jes		May		risc			
2 shorth and the and the and traum		19a. Informant's Na				ahtar						al Route Number				ie,MD 2106	50
1 and f Heal item other		20a. Method of Disp	oosition			20b. P	lace of Dispo	sition (Nam	e of			Date				Town, State	<del>, , , , , , , , , , , , , , , , , , , </del>
Page nent o int: If iry or		1 Durial 2 Donation			al from State	~	emetery, crei atany G				11/06	5/2012	Han	over	. Ma	aryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	Licensee	>		22	2. Name and	Address	s of Facili	ty Ar	natomy (	Gift	s Re	gist	ry	
<u>₽</u> ∪ = 8 9				7										nove	er, N	4D 21076	
N		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final															
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a copsequence of):  Onset and Death  Onset and Death															
Examiner	<u>.</u>	Sequentially list conditions, b. Hypertensi on															
d Sit	Examiner	if any, leading to immediate Duefto/(or as a consequence of):															
xecuted n and al-transi	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):													-		
cate be executed physician and s the burial-transit	ical			L d													
or Attending Physician: The law requires that the death certificate be exter clean. Differ the continuation of the continuatio	Physician/Medica	IF FEMALE:															
eath certifice attending p	ian/	23b. Was decedent in the past 12 r	months?	1 [	es, outcome Live Birth		aldeath 3	Ectopic p		1					ate of del	ivery Day Year	
ne dea / the a ched f	ysic	1 Yes 2 9 Unknown	<b>≰</b> No	9 🗆			Jeath 5L	_ Other (sp									
requires that the de been signed by the should be detached	by PI	Part II. Other signif			_	but not res	sulting in the u	underlying c	ause give	en in Part	1.					the cause of death?	
quires en sig ould b	ted	N 6	one k	nown								1 🗆 1	Yes 2	∑ No	3 🗌 Pr	obably 4 🗆 Unkno	own
has be	Completed											24a. Was autop	osy		Were aut prior to death?	topsy findings availat completion of cause of	ole of
: The la icate ha r, page		05 11/										1 Yes	rmed?			2 🗌 No	
ysfcian: is certific director,	To Be	25. Was case referred examiner?  1 \( \sum \) Yes 2 \( \sum \)		Hospital	: 1   lnna	tiont 2 🗆	ER/Outpatie	nt 3 🗆 DC	Othe	r.		k o <i>nly on</i> e) ome 5 <b>X</b> Resid	donno	e 🗆 Oth	or /Spac	(6.)	
g Phy er this neral d		27. Manner of Death	h		. Date of inj (Month, Da	ury	28b. Time o		ic. Injury work?	at		28d. Describe h					
tendin eath. or: Aff the fur	ifica	1 Natural 2 Accident 3 Suicide	5 Pendi Invest 6 Could	igation				М	1 🗆 🗅	Yes 2							
or Att after d Direct in by	Certificate:	4 Homicide	deterr			jury - At ho tc. (Specify	ome, farm, str	eet, factory,	office				cation (Street and Number or Rural Route Number, ty or Town, State)				
spital		29a. Certifier 1	Certifyin	g Physician: To	the best o	f my knowl	ledge, death	occured at	he time,	date and	place, an	d due to the ca	use(s) a	ınd <b>ma</b> nr	ner as sta	ted.	
To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After the completed filled in by the funeral	Medical	only one) 3	Certifyin	g Nurse Pract	ioner: To the	e best of my	y knowledge,	death occur	ed at the	time, dat	e and plac	ce, and due to th	e cause	(s) and m	anner as		stated.
29b. Signature and title of certifier  29d. Date  29c. License number  29d. Date  29d. Date  29d. Date  29d. Date  29d. Date  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TRANG PHAM, MD  24A MAGTHY BEACH RD, PASADIONA, MD  State  Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature								ate signe	d (Month	, Day, Year)							
		30. Name and addre	os of name	who complete	d called of	death (Itam	23a) (Time 1	Print\	UU	00	26		0	// /	6/2	0/2	_
		TRANG P		MD 2	24A	MAL	TOTHY 1	BEACH	+ R	0.1	ASA	DENA.	M	D	2112	2	
Sta		31. Date filed (Mont	h, Day, Year)	1	32. Regis	rar's Signal	ture			-/-							
Registra	ar	NOV 0 7	2012	Charry	1 10.	1900											

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 35565 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 1245 DM Physician/ Margaret Harlan Ellis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** halfADLITATION CENT AND Birthplace (State or Foreign Country)
 Mauch Chunk If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days 220-30-1945 Director 1 □ M 2 🛛 F June 18, 1919 Pennsylvania 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗌 Yes 2 💢 No Maryland Harford Jarrettsville 0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? , or items 23a 1810 Twin Oak Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married ☐ Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Completed 3 ♥ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leonard Harlan Mary James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn Harrison (Daughter) 1810 Twin Oak Road, Jarrettsville, Maryland 21084 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town. State cemetery, crematory or other p Evans Funeral Chapel Bel Air or other place 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Nov. 07,2012 21. Signature of Funeral Service Licensee Joffrey R. Testerman Evans Funeral Chapel & Cremation Services - Bel Air (M01543)3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 L 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law performed Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frantitioner: To the best of my included a dath occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR, MD 21014 #106. 615 W. MACPHAILRD KHOSUA filed (Month, Day, Year) State NOV 0 Registrar

Emrick, Margaret

		State of Maryland / Department of Health and Mental Hygiene								
	1 State Contificate of Pooth 2012 35566									
		1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death								
Physicia Medi		Margaret I. Emrick  Month Day Year 3 2012 4:05 P M								
Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death								
J	м	Franklin Square Hospital Center Rosedale Baltimore								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)								
Director		Usual Residence of Decedent  1 □ M 2 🖫 F 84 Yrs. 06/05/1928 PA								
shov	호	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
Mary 28e-f	ie	MD Baltimore Eastwood 1 - Yes 2X No								
ith the 23a or at be n	raD	10e. Street and Number 7270 Gough Street 10f. Zip Code 21224 10g. Citizen of What Country? USA								
leath w	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,								
effer d	Completed by	1 Never Married 2 M Married 1 Tyes 2 No No Specify: Specify: White								
-00 lours eture	etec	Year or Dates.								
215 727 31 "	直	15. Decedent's Laucation (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  If a. Decedent's Susual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Lementary/Secondary (0-12)  College (1-4 or 5+)								
within giene giene	ပြိ	12 Office Manager Insurance								
Maryland 21215-0036 12 should be filed within 72 hours efter death with the Maryland lith and Mental Hygiene. 27 is marked other than "neturel", or Items 23a or 28e-f show treumetic event, the Medical Evanihar must be notified at	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Agatha W. Shipe								
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", o may hilury or other treumetic event, the Medical Evan 2010.		19a. Informant's Name/Relationship (Type, Print) Susan Wienhold- Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6811 Bessemer Ave. Dundalk, MD 21222								
imore, I		20a. Method of Disposition  1 Burial 2 TCremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cermetery, crematory or other place)  Atlantic Crematory  11/6/2012  Glen Burnie, MD								
Baltimor permit. Page 1. Department of Importent: If its any Injury or of		4 Donation 5 Other (Specify)  Atlantic Crematory II/6/2012 Glen Burnie, MD  21. Signifure of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler and Son, Inc								
<b>7</b> 88 <b>5</b> 8		Suface Knuke 6224 Eastern Ave. Baltimore, MD 21224								
£	L.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart scilure. List only one cause on each line.  Immediate Cause (Final Onset and Death								
Physician/ Medical		disease or condition resulting in death)  a. Puminary Edema  Due to (or as a consequence of):								
Examiner	_	Sequentially list conditions b Congestive Heart failure								
ed nsit	Examiner	than y leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated even injury								
executed ian and urial-transi	EX3	that initiated events c. Due to (or as a consequence of):								
60 ete be physicia the bu	dical	d								
687 ertific ding p	Ž	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy 23d Date of delivery								
Box 6876 death certificete the ettending phy ned for use as the	Physician/Med	in the past 12 mg/nths?  1 Live Birth 2 Fetal death 3 Ectopic pregnancy  1 Yes 2 No  4 Pregnant at time of death 5 Other (specify)  Month Day Year								
thet the d	Phys	g □ Unknown								
	<u></u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown								
v requests been 2 shou	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of								
Hec The le ate ha	튽	autopsy prior to completion of cause of performed?   prior to completion of cause of performed?   1 □ Yes 2 ☑ No								
clen: ertific ector,	BB (	25. Was case referred to medical 26. Place of Death (Check only one)								
Physical this of the rall directions of the r	은	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)   27. Manger of Death   28a. Date of injury   28b. Time of   28c. Injury at   28d. Describe how injury occurred								
on o nding ath. : After e fune	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year)  28b. Time of injury 28b. Time of injury 38c. Injury at work? 1 ☐ Yes 2 ☐ No								
Division of Vital Hecords, tel or Attending Physicien: The lew requires rs after death.  I Director: After this certificate has been signed in by the funeral director, page 2 should be an incomplete.	ertif	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)								
pitel o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
Division of Vital Heco To the Hospitel or Attending Physiclen: The lew within 24 hours after death. To the Funerel Director: After this certificate has t completely filled in by the funeral director, page 2	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
1.0		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  11-3-12								
low		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Nelia E. Sanchez - Crespo 9000 Franklin Square Drive, Battimore MD 21236								
Sta	te	31. Date filed (Month, Day, Year) 32 Jegistrar's Signature								
Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Nelia E. Sanchez - Crespo 9000 Franklin Square Drive, Baltimore MD 21236  31. Date filed (Month, Day, Year)  NOV 0 7 2012  Address of person who completed cause of death (Item 23a) (Type, Print)  NOV 0 7 2012  Address of person who completed cause of death (Item 23a) (Type, Print)  Nov 0 7 2012  Address of person who completed cause of death (Item 23a) (Type, Print)  Nov 0 7 2012  Address of person who completed cause of death (Item 23a) (Type, Print)								
DHMH 17 Rev 06-	2011									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DGLISH 1800M IDTT 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lowrod If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 D F Months Director Jan Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified toward λL 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 542 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 210 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) naineer 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ overta nomas 19a. Informant's Name/Relationship Type, Print; 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0272 Sor ant 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3 4 Donation 5 Other (Specify) 21. Signature of Full and Service Licensee 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complications that caused to Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 0 equantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Dav Pregnant at time of death Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to ✓ dical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 2012 on who completed cause of death (Item 23a) (Type, Print) 2104 NEL 31. Date filed (Moñth, Day, Year) State Registrar

W DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Edwards 8:00 EM Parker 2019 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Battimore N/A 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Mir (Month, Day, Year) Hours **Director** 245-22-8540 1 XXM 2 □ F 89 NOV. 2 1922 SOUTH CAROLINA Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be notified at Director XX Yes 2 No MARYLAND N/A BALTIMORE 5 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 23a Funeral "natural", or items 23 2825 WESTWOOD AVENUE 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: BLACK 3 Nidowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CHARLOTTE PIPE FOUNDRY PIPEMAKER 6 grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ JIM WHITE ESSIE EDWARDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trac Carla Skinner/Granddaughter 2825 Westwood Ave., Baltimore, Md., 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 11-13-12 OWINGS MILLS, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner per tension Sequentially list conditions to to lor as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Exami The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal Geal 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown the been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 Yes 2 No certificate 25. Was case referred to medical Physician: funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ျ after death.

Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

Registrar X DHMH 17 Rev 06-2011

State

29b. Signature

lichae

NOV 0 7 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Santiago

32. Registrar's Signature

2012

Bon Secours Hospital ED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROSETT 2039 M NOVEMBER 2017 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE NA HOSPITAL SECOURS Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 07-15-35 **Director** 212-30-5093 1 🗆 M 2 🛛 F MD Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 1614 W. Franklin Street 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African Armed Forces?

1 Yes 2 No 1  $\square$  Never Married 2  $\square$  Married þ Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give 3 🖔 Widowed 4 🗆 Divorced Specify: American Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 9th Grade Domestic other homes and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hall Cecilia permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Herman Hall other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4100 Townsend Avenue Baltimore, Maryland 21225 John C. Fields-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
King Memorial Park 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-09-12 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE disease or condition resulting in death) Medical Examiner ARDIO myo Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir -transit that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? has ye 2 after death.

Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 \( \text{Yes} 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural Acci Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier\_

10 am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box SECOMS HOS PITAL 2000 N

2000 WEST BACTIMORE ST BAITIMORE, MD

D30272

Date filed (Month, Day, Year) 32 Registra

Registrar's Signature

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 5 20 T2 4:00 P M Physician/ Elmer George Fugent Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Director 195-18-0042 88 1924 Sept 2, Pennsylvania Usual Residence of Deced 10d. Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21703 5773 Sunset View Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. 1941 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Private Industry 2 Drafting Engineer other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irma Uhliq Carl Fugent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5773 Sunset View Lane Frederick, MD Jan Smith/daughter 20a Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Final Journey Crematory 11/08/12 1 🔲 Burial 2 🔯 Cremation 3 🔲 Removal from State ò Department of Important: If any injury or once. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service Beverly L. Heckrotte, P.A. C. Signatur of Funeral Service Licensee P.O. Box 784 21029 MD Clarksville Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Vece Sequentially list conditions, cause (Disease or injury Due to (or se a nonsequence of Exami that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ Medical Certificate:

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.

Funeral Director: After this certificate has

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 3nt: If item 27 is marked other than "natural", or items 23a or 28a-f sho

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 5 Pending Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, only one)  1 Medical Examiner: On the basis of examination and/o only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, only one)	r investigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s) and manner state
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
( HE DUNKE MD)	1 108104	11/16/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Duski

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Hospital

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 0530 November а Edna Gertrude Fry Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Harmony Hall 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) ial Security Numbe **Funeral** Min Months Hours 1 🗆 M 2 🖳 North Carolina May 15, 1926 Director 245-28-8820 Usual Residence of Deced 86 Yrs 10d. Inside City Limits show 10c. City, Town or Location at 10b. County Director notified 1 🗆 Yes 2 🔀 No 28a-f Charlotte Punta Gorda FL10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ь be USA Funeral 33950 820 Via Tunis 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status an "natural", or ite Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) tother than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Plumbing & Heating 12 Entrepreneur Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked o ည Alice Hoke Roland Alexander Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 7173 Winter Rose Path Columbia, MD 21045 Eva Rose Collins/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/06/12 Woodbine, MD 22. Name and Address of Facility
Going Home CRemation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priviticium/ disease or condition resulting in death) a. Alzbeiner's Dementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day Year in the past 12 months?
1 Yes 2 XNo g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted <del>Living</del> examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 X Other (Specification) 2 X No ٩ filled in by the funeral 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Certificate: iniury 1 X Natural 5 Pending 1 Yes 2 No after death Accident Investigation Accider
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 29b. Signature and title of confifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar M.D.

Hr, Day, Year)

6334 Cedar Lane # 103 Columbia, MD 21044

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 3 2012 Year **HEDY** 07:55AM FOX Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL LAURELWOOD NURSING HOME ELKTON Social Security Numbe . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days (Month, Day, Year) **Director** 024-26-7454 1 □ M 2 🗓 F 92 Yrs. 04/25/1920 GERMANY Usual Residence of Decedent 28a-f shov items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 ALICIA COURT 21901 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian er than "natural", or ite the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes Give 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ PFEFFER WILHELMINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau ROY FOX/HUSBAND 24 ALICIA COURT, NORTH EAST, MD 21901 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 $\square$ Cremation 3 $\square$ Removal from State BALTIMORE HEBREW 11/05/2012 4 Donation 5 Other (Specify) REISTERSTOWN, MD 21. Signa Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause to each line. Interval Between Onset and Death Immediate Cause (Final Physician/ FRESRAL Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, Due to lor as a consequence of if any leasing to immedi cause. Enter Underlying Cause (Disease or injury Exam that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 \( \subseteq \text{Yes} = 2 \subseteq \text{No} \) 24a. Was an autopsy performed? Be ( 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending work? 2 🗌 No ☐ Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) C10002400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 313 West Main Street Ste: A Newrk, DE, 19711

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene									
			State Registrar	Cen	tificate of L	Death		Reg. No. 2012 35573		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				Date of Dea     Month	Day Year		
	Medic	al		FELDN					•	9:05 A <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	SVILLE		4c. County of Death  BALTIMORE		
	Funeral		NORTH OAKS  5. Social Security Number 6. Sex 7. Age (In yrs. last by	birthday)	If Under 1 Year	If Under 24 h	Hrs. 8. Date of Birt	h	9. Birthp	lace (State or Foreign
	Director		578-40-6337 1 D M 2X F	Yrs.	Months Days	Hours N	Min. (Month, Day		Count	
	d ow		Usual Residence of Decedent         95           10a, State         10b, County         10c, City, To		-41		04/07/	191/	1,	IL  Od. Inside City Limits
	ırylan a-f sh ied a	ct							'	1 Yes 2 No
	or 282 notif	[출	MD BALTIMORE P	PIKES	10f, Zip Code			10g. Citizen of Wh	nat Coun	
	vith th	ral	725 MT. WILSON LANE		212	208		USA		, .
	eath v	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. W			(Specify Yes or No- uerto Rican, etc.)	14. Race	- America	an Indian,
98	fter de , or it	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Yes, specify Cuba		uerto Rican, etc.)		, White, e	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 X Widowed 4 LJ Divorced Year or Dates.					Specify:		HITE
5-	72 hc	lg l	15. Decedent's Education (Specify only highest grade completed)	(Give k.	ent's Usual Occup ind of work done o NOT use retired)	ation during most of	working	16b. Kind of Bus	iness/Ind	lustry
12	ithin iene. r thai	ပ္ပြ	Elementary/Secondary (0-12) College (1-4 or 5+)		CRETARY			GOVER	MEN'	Γ
p	ed Fr	Be	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,			
/lar	d be f Venta arked artic ev	ပ	SAMUEL GROSS	5		HANNA	Н		LE	VINE
Maryland	2 should be file Ith and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Number	r, City or Town, Sta	ite, Zip C	ode)
	1 and 2 s of Health item 27 i					IRCLE,	HUNTINGDO			
ore	ge 1 s		1 X Burial 2 Cremation 3X Removal from State ceme	etery, crem	sition (Name of eatory or other place		Date	20c. Location - C	•	
Baltimore,	permit. Page Department of Important: If any injury or once,		4 Donation 5 Other (Specify) KING  21. Signature of Funeral Sender 1 1 500				/04/2012	FALLS (		
Ba	Deperment of the population of		21. Signature of Pulled Applied Constraints				SOL LEVIN			
П			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dyin	g, such as card	diac or respiratory arr	est,		Approximate Interval Between
with	Physician/		Immediate Cause (Final disease or condition	Neto	state	Can	cer			Onset and Death
	Medical Examiner		resulting in death)  Due to (or as a consequence	ce of):			VALUE OF THE PARTY			
		ē	Sequentially list conditions, b. Due to (or as a consequence	ce of):					-	
	rted d ansit	Examiner	Cause Enter Inderlyin Cause (Disease or injury	, .						
	that the death certificate be executed red by the attending physician and a detached for use as the burial-transit	Ä	that initiated events resulting in death) Last C. Due to (or as a consequence	ce of):						
9	te be nysicia he bu	dical	d						_	
87	rtificat ing ph e as t	Me	IF FEMALE:							
Box 687	eath certifica attending pl	ian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date Mont		ery Day Year
Ä.	hat the dea led by the a detached i	Physician/Me	1 🗀 Yes 2 No 4 🗀 Pregnant at time of death 9 🗀 Unknown	n 5L	Other (specify) _					
P.O.	that the		Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	oute to th	e cause of death?
	v requires that is been signed b should be det	ed b					_ 1 🗔 '	Yes 2 7 No 3	3 🗌 Prob	ably 4 🗌 Unknown
of Vital Records,	Physician: The law requires this certificate has been signaral director, page 2 should b	Completed by					24a. Was autor	an 24b. W	ere autop	osy findings available appletion of cause of
Rec	The law ate has page 2	Jom C						rmed? de	eath?	
[a	ysician: The is certificate director, paç	Be (	25. Was case referred to medical examiner?				Check only one)			
Ξ	Physic this or	은	1  Yes 2 No Hospital: 1 Inpatient 2 ER/  27. Manner of Death 28a. Date of Injury 28b			4 Nursir	ng Home 5 Resid			
N 0	ding F h. After funer	ate	1 Natural 5 ☐ Pending (Month, Day, Year)	b. Time of injury	28c. Injur work M 1 🗆			ow injury occurred	1	
Sio	Attending or death. octor: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined	, farm, stre		103 2 110		Street and Number	or Rural	Route Number,
Division	e Hospital or Attendin 124 hours affer death. e Funeral Director: Affer eletely filled in by the fur		building, etc. (Specify)				City or Tow	n, State)		
Standard Program   19   19   19   19   19   19   19   1										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	only one) 3			the time, date ar	nd place, and due to t		inner as s	tated.
	6 → ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥ ≥		<b>*</b>	$\supset$	230. LIGETIST	D37		Octob	14	5105,195
	UDar		30. Name and address of person who completed cause of death (Item 23a	a) (Type, P	rint)		. 1			7/802
	70		St Zbell MT F	Po	Box ?	5613	Salvet	my M	D	2/802
	Star Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	1				/		
			NUVU (ZUIZ / Basel B.	Bask						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:00 A M NOVEMBER 04, 2012 FOX GLADYS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner CHEVERLY PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min. Months Hours 060-26-8755 1 □ M 2 🗓 F Director Yrs 03/27/1927 SCOTLAND 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County must be notified at Director 28a-f 1 Yes 2 X No PRINCE GEORGE'S UPPER MARLBORO MD 10g. Citizen of What Country? 10f. Zip Code 0 10e. Street and Number Funeral items 23a 20774 USA 10922 LAYTON STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Medical Examiner Armed Forces? Black, White, etc. 5 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 XNo Specify If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene.
7 is marked other than "r raumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) OFFICE EQUIPMENT BOOKKEEPER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1.
Department of Health and Mental Important: If item 27 is mmany injury or other. ဂ္ LEVI BARNES MILLIE BARNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10922 LAYTON STREET, UPPER MARLBORO, MD SIDNEY FOX/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
SHINGTON NATIONAL 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/05/2012 SUITLAND, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year Pregnant at time of death Other (specify) been signed by the should be detached Unknown the Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate has 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending injury 1 X Natural death. Accident hours after death Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a
To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

randon Begistrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 [

29b. Signature and title of certifier

only one)

3001

HOSPITAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ber Day 2:50 PM Physician/ 20 SYLVIA FRANK Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hoshital a Baltimore bainmone N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 220-01-5556 Director 1 □ M 2 🕅 F 92 05/17/1920 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should ce filed within 72 hours after death with the Maryland Department of Health end Mental Hygier e. Important: If item 27 is mariled other than "natural", or items 23a or 28e-f sho amy injury or other traumetic event, the Madical Examinar must be natified at once. 10c. City, Town or Location Director 1 🕅 Yes 2 🗆 No N/ABALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21209 USA 3011 FALLSTAFF ROAD, #603 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER ACCOUNTING Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FELDMAN HARRY **EDELBERG** ANNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6113 BENHURST ROAD, BALTIMORE, MD 21209 GLENNA ROSS/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/05/2012 BETH TFILOH CONG. WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coronary Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ed by the attending physicien and detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myelodispiash syndrom 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 066130 November 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE MD EMILIAMO 31. Date filed (Month, Day, Year) NOV 0 7 2012 State Registrar

DHMH 17 Rev 06-2011

Z.

チアインズ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DANIEL CLARKE WHARTON FINNEY, M.D. 2012 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CENTER Baltimore County Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year Sept 9, 1 116-16-1279 Days Hours Country) 1924 Director 1 X M 2 □ F Maryland 83 28e-f shov 10c. City, Town or Location 10a, State 10d. Inside City Limits or then "neturel", or items 23e or 28e-f sho the Wedlost Evanimer must be notified at Pege 1 end 2 should be filed within 72 hours efter deeth with the Merylend Directo Lutherville 1 Yes 2 X No Maryland | Baltimore County 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21093 USA 502 Brightwood Club Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 43 46 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Services Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Depertment of Heaith end Mentel Importent: If Item 27 is merked on eny injury or other traumetic ever once. မှု Margaret Wharton Smith Eben Dickey Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Finney Waller (Daugther) 1507 Old Orchard Lane, Baltimore, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/2012 Catonsville, Maryland Crematory Martin D. Lawson MITCHETT - WEDEFELD FUNERAL HOME, IN 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) <sup>J</sup> Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examine Due to (or as a consequence of): the Hoepitei or Attending Physicien; The lew requires thet the deeth certificate be executed sicien and buriel-tren Due to (or as a consequence of) og physicien es the buriel Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available hes prior to completion of cause of death? efter deeth.

Director: After this certificete I
d in by the funerei director, peg 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 50 C 1 ☐ Yes 2 🕽 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours el To the Funerel D completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinating and/or inventigation in an article of the cause of examinating and/or inventigation in an article of the cause o

State Registrar 29a. Certifier (Check

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 0 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2012

morrida

29c. License number

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ANNIE 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CO Carre TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 💥 F Days Months Hours 25 1927 NORTH CAROLINA 85 Director 215-24-1821 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evantions must be notified at 1X Yes 2 □ No Director BALTIMORE MARYLAND N/A10g. Citizen of What Country? 10e. Street and Number Funeral 3308 ROYCE AVENUE 21215 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: BLACK ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAL ENGINEER MAINTENANCE 10th grade marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) I 2 should be fill h and Mental H 7 is marked ott Be ပ FRELAND LAWRENCE WILLIE LEE KEARNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 1103 Scotts Hill Dr., Baltimore, Md., 21208
of Disposition (Name of Date 20c. Location - City or Town, State 21208 Ferriel Marshall Sparrow/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11-05-12 WOODLAWN CEMETERY WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lies 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVENUE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-trar physician the burial Box 68760, Physician/Medical as IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed 2 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0073324 WD woods Rob, for kuille, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) waltrom 8813 NIA2 FA12A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2012 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryla	-	artment of H <i>tificate of E</i>			iene eg. No. 2012	35578		
		Decedent's Name (First, Middle, La.	st) Callin				2. Date of Death	h	3. Time of Death		
Physic /Medi	cal	4a. Facility Name (If not institution, giv	HRA GRIF	FITH	4b. City, Town, or	Location of Death	Novemb	10 Venber 6 2017 0232 AM			
Exami	ner	Johns Hopkins Bayvi		er	Baltimore	Location of Death		Baltimore	Citv		
Funeral		Social Security Number     6. S	Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthpl Countr	ace (State or Foreign y)		
Director		216~20~9720 Usual Residence of Decedent	□M 2×1   87	113.			7-16-1	925	Md.		
aryland s <b>how</b> dat	5	10a. State 10b. County		City, Town or Lo				11	0d. Inside City Limits 1 ☐ Yes ※ No		
the M 28a-f	Directo	Maryland Baltimo	re		Balt 10f. Zip-Code	cimore Cou		Og. Citizen of What Count			
th with 23a or st be r		719 S. 50th St.				21224		USA			
er dea items	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - America Black, White, e			
Fey, IVIAITY INTELL 12-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ğ	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 XNo	Specify:		Specify: Wh:	ite		
"natur	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of workir	ng	16b. Kind of Business/Inc	dustry		
within iene. than be Me	dwo	Elementary/Secondary (0-12)  12th grade	College (1-4 or 5+)		maker	)		Homemaking-(	Own Home		
yiarid < 1 < but shall be filed with Mental Hygiene. arked other than atte event, the M	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Surname)			
should be and Mental marked of marke	卢	John Brill  19a. Informant's Name/Relationship (	Time a Defeat	405 14-11	A did (O44	Edith Eli		Wilson r, City or Town, State, Zip	Code		
and 2 sho ealth and I n 27 Is me		Beverky D. Rosenb	**	I .	-	1 Lane Be			Code)		
of Health		20a. Method of Disposition			osition (Name of matory or other plac		ate	20c. Location - City or Tov	wn, State		
Datimo		4 Donation 5 Other (Speci	(y) P		Cemetery			Baltimore, N	Md		
Dattimore, permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21 Signature of Funeral Service Licer	isee	2	2. Name and Addres	LUC	ssahn Fu altimore	neral Home , Md. 21236			
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	ath. Do not en	ter the mode of dyin	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between		
Physician	ı	Immediate Cause (Final disease or condition	_aACI	ute a	many	Syndra	ome		Onset and Death		
/Medical Examiner	ı	resulting in death)	Due to (or as a cons	equence of):	us cula	Syndra C Dises	201.				
	iner	Sequentially list conditions, if any, leading to immediate	b.  Due to (or as a conse		VW CILLY	1000	1,0				
ecuted ind -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	adulance of							
orou, icate be executed physician and s the burial-transit	edical E		d.	041000 01).							
oo/ tificate ig phys		IF FEMALE:	9.			- (					
VITAI MECOTICS, P.O. BOX bostellars: The law requires that the death certificate has been signed by the attending plicetor, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1					23d. Date of deliver	ery Day Year		
the de	hysic	1  Yes 2 No 9 Unknown	9 Unknown	i death 5	Other (specify)						
S, T,	þ	Part II. Other significant conditions  Diwatts M	A A M	resulting in the	underlying cause gi	iven in Part I.		bacco use contribute to the	M		
aw requires the beautiful to the second of t	eted	DIMPOTO IV	WILM 2				1 🗌 Ye		ably 4 Unknown psy findings available		
he law has b	Completed						autops perforr	sy prior to co	mpletion of cause of		
VITAL clan: T ertificate ector, pa	Be	25. Was case referred to medical examiner?		- 1		26. Place of Death					
OT VITA Physician: this certific aral director,	ြု	Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4 - Ivursing noi		ence 6 Other (Specify	)		
ding I	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl		200. 2000.120 11	on injury coodined			
or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not l			reet, factory, office		28f. Location (S City or Town	treet and Number or Rura n, State)	al Route Number,		
pltal o		29a, Certifier 1 Certifying P	hysician: To the best of my k	nowledge, dea	th occurred at the tir	me, date and place,	and due to the o	cause(s) and manner as s	stated.		
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page	edical		miner: On the basis of exami and manner stated.								
withii 70 th	ĕ	29b. Signature and title of celtifier	1/2/1 1	1 11	29c. Licens	e number	117 2	29d. Date signed (Month, November			
		30. Name and address of person who	completed cause of death (	Item 23a) (Type	Print)	1725	45	14014.034	0,0-10		
3~		GABRIT	CILEA	100	WET N	D 4940 E	astern Av	enue, Baltimoi	re, MD, 21224		
St Regis	ate trar	NOV 0 7 2012	32. Registrar's Sig	nature							
		11011	Maria , bo to								

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert Galloway, Sr. Vovember 10.00 AM 2.0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel FutureCare Chesapeake Arnold Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 212-30-9033 **Director** 1 X M 2 🗆 F 79 April 23,1933 Maryland Usual Residence of Decedent 28a-f show 10a, State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Maryland Anne Arundel Gambrills 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1028 Springhill Way 21054 United States Page 1 and 2 should be filed within 72 hours after death norment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and Mental Hygiene.
Is marked other than "natural", or iten 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) Housing Authority 12 Maintenance Man Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Zeak Oliver Galloway Georgiana Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Earl Galloway, Jr./Son 1028 Springhill Way, Gambrills, Maryland 21054 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Arundel Other place)
Crematory 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20**1**2 November Odenton, Maryland 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Etarien M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Endstage disease or condition Medical resulting in death) Due to (or as a consequent e of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be exectiviting 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician are completely filled in by the funeral director, page 2 should be detached for use as the human. Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760  $\mathscr C$ Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3

State Registrar olveterans Muy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D5 7531

Suite voy, meyersvice

November 2.

md 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death t's Name (First, Middle, Last) Physician/ Medical 4b. City, Town, or Location of Death Examiner Baltimore s. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign Funeral Days Months Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: If them 27 is marked other than "natural", or items 200 - - - - any injury or other treumatin 10a. State Director 1 Yes 2 No olumbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral reek 104 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black White, etc. 1 Yes 2 No ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ndary (0-12) College (1-4 or 5+) Omestic Be 18. Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21229 Funeral Service Licensee 21. Signature 70 Fredhilton Pass Balto. mo 23a. Part 1 Enterine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ne umorvia Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after deeth. signed by the attending physician and id be detached for use es the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Day 1 Tes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 5 ☐ Residence 6 ☐ Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29d. Date signed (Month, Day, Year) 303 0 ed cause of death (Item 23a) (Type, Print) 516 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RU 2 2.20M 30,2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Baltimore City

9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, **Funeral** 1 X M 2 🗆 F 92 Days 035-18-9311 12-17-1919 Director Rhode Island Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 1 Yes XXNo Director MD Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code death with <u> 2800 Ritchie Avenue</u> Funeral <u>United States</u> Was Decedent Ever in U.S Armed Forces? 1XX Yes 2 □ No If Yes, Give 0 C t 10 Year or Dates: 0 C t 10 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1941 1963 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Investor Financial 12 years 4 years 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Rowland Gaunt Winifred Carter ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teri O'Donnell (daughter) 338 Harlan Square, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Hilltop Nov. 5,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Qunature of Funeral Service III ev ee Wise Avenue, Dundalk, MD 21222 mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cau, on each line. Immediate Cause (Final disease or condition resulting in death) ASPIROL TON Due to (Ir as a consequence of): **Physician** umonic /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence ut) nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 □ No 1 Yes 2 N/No 1 Tes certificate 26. Place of Death (Check only one) or Attending Physician: funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ₩No 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation Injury 1 Tes 2 No death. 2 Accident after death Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOVO 7 Registrar A. parked DHMH 17 Rev 1/2001

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			rtificate of	Death		Reg. No. 7	12	35582
	Physicia	an/	1. Decedent's Name (First, Middle, La	,	-			2. Date of De Month	Dav	Year	3. Time of Death
Medic Examir			Herb  4a. Facility Name (if not institution, giv		Garı	ison	or Location of Death	Nov.	2 2C	12	11:26 A <sup>M</sup>
	LAGIIII		_ 3400 North Point Road Dundalk						,		re Co.
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	(Month, Da	th v, Year)		lace (State or Foreign
	Director		Usual Residence of Decedent	1 <b>X</b> □M 2□F 79	Yrs.			April	10,1933		ginia
	f shoved at	ţoţ	10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	e Man r 28a- notifie	Director	MD Balt  10e. Street and Number	imore			Dt	ında1k			1 ☐ Yes 2 X No
10.00	with th	Funeral I	3400 North Po	int Road		10f. Zip Code	222	1	10g. Citizen of W		•
	death items ner m		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race	- America	an Indian,
036	filed within 72 hours after death with the Maryland the Hygiene. Alygiene. Alygiene do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 □XYes 2 □ N If Yes, Give Year or Dates. 1 €	0	1 ☐ Yes 2X No		, ,	Specify:	k, White, e	hite
Maryland 21215-0036	72 hou n "natu edical	Completed	15. Decedent's (Specify only highest g	Education	16a. Dece (Give	dent's Usual Occu kind of work done	during most of won	king	16b. Kind of Bu		10-1-1-1
717	filed within a tal Hygiene. d other than event, the M		Elementary/Secondary (0-12) 9 Years	College (1-4 or 5+		OO NOT use retired Builder			Steel	Indu	stry
nd	filed v al Hyg d othe vent,	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surname,		
<u>Z</u>	uld be fi I Mental narked natic ev	은	Andy George (						rence Ke		
	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship ( Virgie D. Szymar		er) 19b. Maili 122	ng Address (Street 21 Willow	and Number or Rui Road Du	ral Route Numbe indalk,	r, City or Town, Si Maryland	ate, Zip C 21	222 2
2	Page nent o ant: If iry or		29a. Method of Disposition 1   → Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	wn, State
			4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer			Cemeter	v 11/	/6/2012	Balti	more	, Maryland
ă	permit. Departr Imports any inju		Jent a Con	Justin A.	Jones   1	Ouda-Ruck 7922 Wis	ss of Facility Funeral se Ave. Di	Home of	Dundalk Maryland	t <b>,</b> In	C. 222
			232 Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused to one cause on each line.	ne death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory an	rest,	1	Approximate Interval Between
P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ostes	myeliti					-	Onset and Death
	Examiner	L	Cognostially list and divisors	Simil	Stense	Swage	2				
	ed nsit	Examiner	Sequentially list conditions, that you had not been cause. Enter Underlying Cause (Disease or injury	Perkin	onsequence on:						
	uncate be executed by physician and as the burial-transit	Exa	that initiated events resulting in death) Last	С.	consequence of):						_
00/0	hysicia the bur	Medical		Id. Demo	motion	, AL 12	estimons			$\perp$	
0	g 60 g		IF FEMALE:	23c. If yes, outcome of	pregnancy						
YOU	the attendin	Physician/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date Mor	e of delive th	ry Day Year
5	led by detac	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	obacco use contri	bute to the	e cause of death?
orus,	been signed by the should be detached							1 🗆	Yes 200 No	3 🗌 Prob	ably 4 🗆 Unknown
בר ב	has be	Completed						24a. Was autop	osy p		sy findings available npletion of cause of
	certificate ha rector, page	a l	25. Was case referred to medical			26 P	lace of Death (Chec	1 L Yes		Yes	2 🗌 No
VILC	is certifical	To B	examiner? 1 ☐ Yes 2 D No	Hospital: 1  lnpatien	t 2 ER/Outpatier	Oth	er:	-/	dence 6 🗆 Other	(Specify)	
5 5	h. After th funeral		27. Manner of Death  17 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	/ear) 28b. Time of injury	worl	y at </th <th>7</th> <th>ow injury occurred</th> <th></th> <th></th>	7	ow injury occurred		
	er death.	ertificate	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined		- At home, farm, str		Yes 2 □ No	28f. Location /S	itreet and Number	or Rural I	Route Number
בַּ בַּ	eral Dire	ျပ		building, etc. (	Specify)			City or Tow	rn, State)		
Hook Hook	Fun 4 h	Medical	only one) 3 Certifying Nur	sician: To the best of my iner: On the basis of exa se Practitioner: To the b	mination and/or inves est of my knowledge,	tigation, in my opini , death occurred at	on, death occurred a the time, date and pl	t the time, date a ace, and due to t	nd place, and due	to the caus	se(s) and manner stated
Ļ	within 2 To the comple	200	29b. Signature and title of certifier	Hum		29c. Licens	e number ) 3 6 9 57		29d. Date signed		
1			30. Name and address of person who 21. Date filed (Month, Day, Year)	completed cause of dear	th (Item 23a) (Type, F	Print) 9/14,	Philodolym 108	RL:	11/ Boldinore	MZ,	237
Ą	Stat Registra	e ar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	,					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month WALTER FRANCIS GORMAN Medical NOVEMBER 2012 9:30 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6503 UPLAND ROAD **FORK** BALTO Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
JUNE 30,1922 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min 182-18-7557 Director MARYLAND 1 **X**M 2 □ F 90 Yrs Usual Residence of Decede show 10a, State 10b. County 72 hours after death with the Maryland or then "naturel", or Items 23e or 28e-f sho 10c. City, Town or Location 10d. Inside City Limits Director BALTO. MD. FORK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6503 UPLAND ROAD USA 21051 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever III U.S. Armed Forces?

1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. 1942–1946 Black, White, etc. il Hyglene. other then "naturel", or δ 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PROD. CONTROL OFFICER NATIONAL CAN COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental I ဍ permit. Pege 1 and 2 should be Depertment of Health end Men Importent: If item 27 is marke eny Injury or other treumetic once. CHARLES J. GORMAN ROSA M. LEIGHTNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NIECE 6503 UPLAND ROAD FORK, MD. 21051 JANICE WHEELBARGER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL MEMORIAL 11-7,2012 MIDDLE RIVER, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARTERY DISEASE CORONARY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 15 YEARS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sicien end burial-transit Exami or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 s attending physic d for use as the t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at t be deteched for 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2-□ No 24a. Was an hes autopsy performed? Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 1 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1, 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 22620 2012 11/6/

Registrar

State

31. Date filed (Month

SHAHID SAEED MD, 6830 HOSPITAL DRIVE, BALTIMORE, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		partment of Health and Mertificate of Death	lental Hygiene	5.012 3	5584	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Lucille M.	Gorham		2. Date of Death Month Da		Time of Death	
1	/Medic Examin		4a. Facility Name (If not institution, give str Union Memorial F		4b. City, Town, or Location of Death Baltimore		c. County of Death	,	
ı	Funeral Director		210 20 0730	7. Age (In yrs. last birthda 81 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Jan . 10, 1	9. Birthplace Country) N.C	(State or Foreign	
	Marylend -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Balt	Location	9-1-1-1-1		Inside City Limits	
21215-0036	h with the	ai Direc	10e. Street and Number 3418 Kentucky	Ave.	10f. Zip Code 21213		itizen of What Country? JSA		
	urs after deet al', or iteme 2 Examinar mu	by Funeral Director	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give X Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2□ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American II Black, White, etc. SpecifyBlack	ndian,	
	l within 72 ho iene. r than "natur i a Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	Completed) (Gi life College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work one DO NOT use retired)  nmunity Activist	ing	Kind of Business/Industr		
Maryland 2	uld be filed Jental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last)  Lee Alexande:	2	18. Mother's Name Loui	e (First, Middle, Maide se Davis			
, Mary	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Importent: if Item 27 is marked other than "netural; or items 23s or 28s-f show any fujury or other treumatic event, it is Medical Examinational be notified at ance.		19a. Informant's Name/Relationship (Type Sallie Gorham (c	daughter) 143	illing Address (Street and Number or Run N. Kenwood Ave	. Balto,			
Baltimore,			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Rei  4 □ Donation 5 □ Other (Specify)	Arbuti	rematory or other place) as Mem.Pk. Nov.	9,2012Ba	ltimore,		
Bal	Depermine the permit of the pe		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications of the service Licensee.		22. Name and Address of Facility Calvin B. Scrug 1412 F. Preston enter the mode of dying, such as cardiac	St. Bali	to.Md. 21	213	
	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line	DYSILASTIL S		1K	proximate erval Between set and Death	
	Examiner	ıer	Sequentially list conditions, if any, teacing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
8760,	deeth certificate be executed e ettending physicien end of for use es the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
Box 6	deeth certific e ettending p nd for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day	y Year	
ds, P.O.	₽ B B	<u>م</u>	Part II. Other significant conditions conti	ributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the c		
I Records,	The law requires ete has been sign page 2 should be	Completed				24a. Was an autopsy performed?	death?	etion of cause of	
i Vita	iding Physician: Th (h. Atler this certificete funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 ☐ Inpatient 2 FER/Outpa	Others	th Check onlone ome 5 Residence	6 ☐Other (Specify)		
o uo	Attending Ph r death. ctor: After th y the funeral		27. Manner of Dean  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injur		28d. Describe how inj	ury occurred		
Division of Vital	5 # 5 E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	on (Street and Number or Rural Route Number, r Town, State)		
	To the Hospitei or At within 24 hours after or To the Funerei Direct completely filled in by	Medical (	29a. Certifier (Check only one) Certifying Physical Examinu	cian: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur investigation, in my opinion, death occur	and due to the cause( red at the time, date a	(s) and manner as state nd place, and due to the	e cause(s)	
	Within To the comp	M	29b. Signature and title of certifier	re MD	29c. License number D.71.56.2		Date signed (Month, Day	2012	
•	Harl		30. Name and address of person who con	impleted cause of death (Item 23a) (Type	De, Print) Jessica S	me MD	1/2/2	8	
8	Sta Regist		31. Date filed (Month, Day, Year)  NOV 0 7 2012	92. Registrar's Signature	W STATE OF THE STA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct. Physician/ 2012 29 13:35 P™ Henderson Alethia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore Sinai Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 08-27-23 Days Hours Min. Country) 217-18-5565 MD **Director** 1 □ M 2 1 F permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No NA Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 6915 Park Heights Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. African Armed Forces?

1 Yes XX No
If Yes, Give
Year or Dates. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NA 12th Grade Laborer Various jobs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Thomas Virgie Thomas Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 N. Smallwood Street Baltimore, Maryland 21216 Sabrena Karin-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other partison Forest 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 11-13-12 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the at Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been si should 24b. Were autopsy findings available 24a Was an pnor to completion of cause of death? this certificate has ral director, page 2 autopsy performed? 1 ☐ Yes 2 X No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

3 W.

DHMH 17 Rev 06-2011

State Registrar M.D

772

Newlan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schwa

Tau

31. Date filed (Month, Day

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1-3-2012 D:30AM onnie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death imore 05 0W501 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Hours Min. (Month, Day, Year) Director 1 MM 2 □ F 58 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih end Mental Hygiene. Important: If item 27 is anawade other than "natural;", or items 23e or 28e-f ahow any injury or other traumetic event, it is Medical Eventher must be natified at any injury or other traumetic event, it is Medical Eventher must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 2009 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Divorced 4 Divorced Completed Year or Dates lack Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) horeMan Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) amil ton 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kesville MD Funeral Service 21. Signature of Funeral Service Licensee 22. Name and Add 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of nijury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and I for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlyi<mark>n</mark>g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funerei Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) မြ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗆 Yes 2 🗀 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

M

State Registrar only one)

31. Date filed (Month, Day, Year)

29b. Signatur and title of certifier

NOV 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAR

Registrar's Signature

6701

29c. License number

8303

C

harles

29d. Date signed (Month. Day, Year)

2012

5

DHMH 17 Rev 1/2001 DCME 2006

State Registrar 31. Date filed (Month, Day, Year)

32. Registraris Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35588 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4 2012 Month Physician/ 2:29 Margaret A. Harrington November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months Davs Hours 217-40-5742 Director 1 □ M 2 🕅 F 69 Yrs. March 25,1943 New Jersey permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b County 10a, State 10c. City, Town or Location Director 1 Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 United States 8620 Kelso Drive, Apt. A 103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Doctor's Office X-Ray Technician Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cardamone Margaret Robert R. Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Franklin Ave., Apt. 507, Essex, MD 21221 Kathleen Harrington / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 D Burial 2 X Cremation 3 D Removal from State Metro Crematory Inc. 11/05/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Thomas Gregor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 2 🗶 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 5 Pending Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

NOV 0 7 2012 32. Registrar's Signature State Registrar

MARGARET HARRINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 2, 20 Physician/ 0800 M Bernice R. Hess Medical 4a. Facility Name (if not institution, give street and number 4b\_City, Town, or Location of Death 4c. County of Death Examiner Samalitar N/A 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Security Number **Funeral** (Month, Day, Year) Hours 196-16-3180 Director 1 □ M 2 🂢 F 87 Feb. 1,1925 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, t<u>he Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Towson Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21204 502 Baltimore Avenue, Floor 1 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Industrial Products Management t. Page 1 and 2 should be filed w rtment of Health and Mental Hygi-rtant: If item 27 is marked other njury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Llovd D. Geho Millicent Butz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BCDA, 611 Central Ave., Towson, Maryland 21204 Donna Brill / Guardian Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 XCremation 3 Removal from State Metro Crematory Inc. 11/03/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licen ee Thomas Gregor 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending phase at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Pregnant at time of death signed by the at Yes 2 No 1 ☐ Yes 2 ₺ 9 ☐ Unknown P.O. Part II. Other significant qonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, this certificate has been signal director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 🗌 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |2 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) 5001 Loch un State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charles Howard Heinlein 6:50 pM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours Director 90 213-14-0784 1 XM 2 □ F Mar. 6,1922 28e-f shov in then "neturel", or items 23e or 28e-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 907 Rock Hill Avenue 21229 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Sheet Metal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mental F is merked or Frederick Heinlein Susan Yeager 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Depertment of Heelth er Important: If Item 27 is eny injury or other treu 2034 Wexford Green Drive Valrico, FL 33594 Darlene V. Gawel- Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NOVEMBER Loudon Park Cem. 11/6/2012 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Brown-Simons 4107 Wilkens Avenue Baltimore, MD 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CORONARY ARTERY DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed siclen end burlal-tran Due to (or as a consequence of) resulting in death) Last ettending physicien I for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Hospitel or Attending Physicien: The law requires that the deeth Day 5 Other (specify) HEINLEIN the t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cete has been sig ; page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CHARLES 24a. Was an autopsy performed certificete Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Yes 2 X No <u>۾</u>| 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No s efter death.

I Director: All of in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter
To the Funerel Directory
completely filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29d. Date signed (Month, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar NOV 0 7 201 (XDHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	-	Department of Certificate of			giene Reg. No. 2 N	2 35591	
	Dhysisis	m/	1. Decedent's Name (First, Middle, Last)			obbs		2. Date of Dea	ath	3. Time of Death	
	Physicia Medic	al	Mark  4a. Facility Name (if not institution, give st	Kevin	n		and another of Danith	Nov.	5 2012		
	Examin	er	3565 McShaneway			Dunda	or Location of Death $1\mathrm{k}$		4c. County of D Balt:	imore Co.	
	Funeral Director		5. Social Security Number 6. Sex 214-90-3415		(In yrs. last birth	oday) If Under 1 Yea Months Days		8. Date of Birt (Month, Day 10/24/1	h 9. // Year) 9. // 963	Birthplace (State or Foreign Country) Maryland	
	and show at	or	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	Maryl 28a-f notified	Director	MD Baltim	ore			Dı	ında1k		1 Yes 2 X No	
	vith the 23a or st be r	eral E	10e. Street and Number 3565 McShaneway			10f. Zip Code	222		10g. Citizen of What United	•	
	death v	Funeral	The state of the s	2. Was Decedent Ev Armed Forces?		13. Was Decedent of		ecify Yes or No- Rican, etc.)		merican Indian,	
036	s after ral", or Exami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 💢 N If Yes, Give Year or Dates.	lo	1 ☐ Yes 2 💢 N	o Specify:		Specific	White	
2-0	2 hour "natur edical	Completed	15. Decedent's Edu (Specify only highest grad	cation	1/3	Decedent's Usual Occu (Give kind of work done		16b. Kind of Business Industry			
7121	vithin 7 liene. Ir than the Ma		Elementary/Seconday (0-12)	College (1-4 or 5-					Manufac	turing	
pu	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)		•				Maiden Surname)		
ıryla	ould be id Men marke matic		G. Paul Hobbs  19a, Informant's Name/Relationship (Typ)	e. Print)	19h	Mailing Address (Stree		Lee Tom		Zin Codel	
, Na	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Susan L. Hobbs	(Sister)		455 Loganv					
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F	Removal from State	cemeter	Disposition (Name of y, crematory or other pl	ace)	Date	20c. Location - City		
atir	nit. Pa vartmer vortant injury		1 ☐ Donation 5 ☐ Other (Specify)  21. Signa e of Funeral Service License	Domnia	Garden	s of Faith			Dundalk,	re, Maryland	
ä	Imp any				W	7922 Wise	e Ave. Dun	<u>dalk, M</u>	aryland 2	21222	
			23a: Part 1: Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	the death. Do no er Cirrh		ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death	
	Physician/ Medical		disease or condition resulting in death)		consequence o					2 Years	
-	Examiner	<u>_</u>	Sequentially list conditions,			Varices				2 Years	
	ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence o	īj.					
	cate be executed physician and s the burial-transit		that initiated events cresulting in death) Last	Due to (or as a	consequence o	f):		-			
200	physic the bu	edical		l							
Box 68760	ending use as	an/M	23b. Was decedent pregnant	3c. If yes, outcome o		3 ☐ Ectopic pregna	23d. Date of delivery				
. Bo	requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at g ☐ Unknown		5 Other (specify)			Month	Month Day Year	
Division of Vital Records, P.O.	s that the gned by be detailed	ρ	Part II. Other significant conditions con	tributing to death bu	t not resulting in	n the underlying cause	given in Part I.			e to the cause of death?	
rds	require been si should	Completed						24a. Was	an 24b. Were	Probably 4 Unknown autopsy findings available	
3ec	sician: The law r certificate has k irector, page 2 s	omo						autop	osy prior rmed? death	to completion of cause of	
tal	ician: T sertifica ector, p	Be	25. Was case referred to medical examiner?	ospital:			Place of Death (Chec				
of V	g Phys er this eral dir	e: To	27. Manner of Death	1 Inpatie 28a. Date of injun	/ 28b. T	tpatient 3 □ DCA imme of 28c. Inj.	4 □ Nursing H		lence 6 Other (S) ow injury occurred	pecify)	
ion	tending leath. or: Afte	Certificate:	1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			M 1	rk? ☐ Yes 2 ☐ No				
Sivis	al or At s after o l Direct d in by		4 Homicide determined	28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		er: On the basis of ex	amination and/or	r investigation, in my opi	nion, death occurred a	t the time, date a	nd place, and due to t	he cause(s) and manner stated.	
	To the within To the compl	Σ	only one) 3 ☐ Certifying Nyrse 29b. Signature and title of certifier	/ I determine to the t	est of my known		se number		29d. Date signed (Mo	onth, Day, Year)	
				//		Free Date 9	44195		Nov. 6, 2		
)			30. Name and address of person who co	mpleted cause of de $6730~{ m Holat}$			re, Maryl	and 21	222		
1	Star Registra		31. Date filed (Month, Day, Year)  NOV 0 7 2012	32. Registrar	's Signature	4.3					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 3, 2012 Year Physician/ 9:00 A.M. ANTONI HORODOWICZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TIMONIUM BALTO. STELLA MARIS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Country) Director 215-44-0231 1 XM 2 □ F 84 Yrs 2-26-1928 **POLAND** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examingr must be notified at 10d. Inside City Limits 10b, Count 10c. City, Town or Location BALTO. KINGSVILLE Direct MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12144 JERUSALEM ROAD 21087 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Black, White, etc. Armed Force 1 Yes 2 No 1 Never Married 2 X Married ģ WHITE Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced a.m. Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) AUTOMOTIVE Elementary/Secondary (0-12) College (1-4 or 5+) 12TH MECHANIC GARAGE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ZOFIA ATAMANCHUK MICHAEL HORODOWICZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12144 JERUSALEM ROAD KINGSVILLE, MD. 21087 SPOUSE TATJANA HORODOWICZ 3 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State NOVEMBER 11-10-2012 GLEN BURNIE, MD. ATLANTIC CREMATORY 4 Donation 5 Other (Specify) SCHIMUNEK FUNERAL HOME, INC. 22. Name and Address of Facility Signature of Funeral Service Licens 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ANTONI HORODOWICZ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 XNo 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) HOSPICE 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Hospital within 24 hours a To the Funeral C

State

29a. Certifier

(Check

only one) 29b. Signature and title o

31. Date filed (Month, Day, Year)

certi

Name and address of person who completed cau

MORGAN,

Registrar DHMH 17 Rev 06-2011 death (Item 23a) (Type, Print)

2300 DULANEY

of

**CRNP** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 XX Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM,

29d. Date signed (Month, May, Year)

MD 21093

29c. License number

VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howard Lewis Hamilton 5:30 рм 2012 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9506 Buckhorn Road Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 215-32-6288 Director 1 X M 2 D F 76 Maryland December 9,1935 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dundalk Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3425 Yardly Drive 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify. White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mexicol Elementary/Secondary (0-12) College (1-4 or 5+) Brick Layer Construction 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Lewis Hamilton Mary Emma Smeltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Beres-Starkey 9506 Buckhorn Road, Parkville, Md. 21234 Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 Burial 2X Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation → ☐ Other (Specify 7, 2012 ress of Facility Funeral Home of Dundalk, P.A. 22. Name and Adda Connelly 7110 Sollers Point Road, Dundalk, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) END STAGE LUNG CANCER 6mths Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine Due to (or as a consequence of): as been signed by the attending physician and 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 2 X No 1 Yes 25. Was case referred to medical Hospital or Attending Physician: the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{XOther (Specify)} \) 1 Yes 2 🗷 No Daughtens ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier within 24 hou To the Fune completely fi 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 To the only one) Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0054739 MA NOVEMBER, 05th, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 204, GLEN DAKWOOD RD. 21061 BURNIE MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 1 2012 8:30 A Heath Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 651 47th Street Dundalk Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 215-30-0632 Director 78 January 3, 1934 1 □ M 2 🕅 F Pennsylvania 27 is merked other then "neturei", or items 23e or 28e-f show treumatic event, the Medical Examinar must be nutfilled at 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location death with the Maryland Director MD Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 651 47th Street 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒No If Yes, Give within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and 2 should be filed within 72 Health end Mental Hygiene. tem 27 is merked other then " Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 12 vears æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Blakney Lena Bisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 651 47th Street, Dundalk, Maryland 21224 Barbara Morrison Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State November permit. Pege 1 a Depertment of H Importent: If ite eny injury or ot 1 X Burial 2 Cremation 3 Removal from State Dundalk, Maryland Oak Lawn Cemetery 6, 2012 4 ☐ Donation 5 ☐ Other (Specify) Sign ture of Ju Connelly Funeral Home of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on such line Immediate Cause (Final disease or condition Physiciana Medical resulting in death) cuence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of Examir inding physicien end use es the burlal-transit Cause (Disease or injury To the Hospitei or Attending Physicien: The law requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 signed by the ettending d be detached for use ex IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 🗌 Yes 2 🗆 No Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an pege 2 autopsy performed? Yes 2 No has prior to completion of cause of death? this certificate 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific, completely filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Division Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Seatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date

2 lb

State Registrar 30. Name and address of per≰

9

31. Date filed (Month, Day, Year)

NOV 0 7 2012

Acres Signature

completed cause of death (Item 23a) (Type, Print)

12

02

2-08313	Please Type or Print in Bla	ck Indeli	ole ink. Ensure All Co	pies Are Leg	ible.	
Edward Charles He	inbuck, Jr. State of Maryland /		ent of Health and Menta ate of Death	il Hygiene	2012	2 35595
	Registrar	Certifica	tle or Death	2. Date of Death	g. No.	3. Time of Death
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)  Edward Charles Heinbuc	k Tr			Day Year	0155 hrs
	4a. Facility Name (if not institution, give street and number)	K, JI.	4b. City, Town, or Location of I		4c. County of Death	) 1
	Carroll Hospital Center		Westminster		Carroll	
Funeral	5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Year If Under 2  Months Days Hours	24Hrs. 8. Date of Birth Min.	n(MM/DD/YYYY) 9. Bir Foreig	an
Director	216-13-0220 1∑M 2□F	40	Yrs. Month Bayo Hours	Nov 14	, 1971 Co	ountryMaryland
ás .	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
i tow any	,		nt Airy			1 Yes 2 No
nryland	Maryland Carroll  10e. Street and Number	19001	10f. Zip Code	10	g. Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once	201 West Watersville Road,	Apt. 27	21771		USA	
with t	11. Marital Status 12. Was Decedent I		13. Was Decedent of Hispanic Origin			ican Indian, Black,
r death with or items 23		X No	If Yes, specify Cuban, Mexican, P	ruerto Ricari, etc.)		
s after ral", o	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 1 1 10- 5	1 Yes 2 No specify:	ad of work dono	Specify: Whi	
hours frature	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5		Decedent's Usual Dccupation (Give kir luring most of working life. DO NOT us		TOD. KING OF BUSINESS/	madaty
36 Fin 72 C. than dical	12		rinkler Fitter		Virginia S	Sprinkler
5-0036 led within 72 hour hygiene. other than "natu the Medical Exan Completed	17. Father's Name (First, Middle, Last)			Name (First, Middle, M	aiden Surname)	
D 21215-0036 should be filed within 7 and Mental Pygiene. 7 is marked other than natic event, the Medica To Be Comple	Edward C. Heinbuck			Irma Lucas		
2121 hould be fil and Mental H is marked ritic event, I	19a. Informant's Name/Relationship (Type, Print )	111	. Mailing Address (Street and Number			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Terri Aiosa, Sister	20b Place 0	020 Spriggs Drive f Disposition (Name of cemetery,	Mount A1	TY, MD ZI/ 20c. Location - City or	/ <u>L</u> Town, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If iten 2 injury or other traun	1 Burial 2 X Cremation 3 Removal from Sta	te cremato	ory or other place)		-	
Lim : Pag tment rant:	4 Donation 5 Other Specify:		Crematory Inc.	11/05/12		e, Maryland
Balti permit. Departr Import	21. Signature of Funeral Service Licens Thomas	regor	22 Name and Address of Facility Cremation Socie 299 Frederick R	ty Of Mary	land, Inc.	and 21228
Physician	23a. Part I. Enter the disease, or complications that caused to	the death. Do no	t enter the mode of dying, such as car	diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical	failure. List only one cause on each ling.		e) and alcohol in			Death
Examiner	or condition resulting in death)  Due to (or as a conse		er and arconor and	22.0-23.2-22.0		
<u> </u>	Sequentially list conditions, if any leading to immediate b.  Due to (or as a conse	dience of).				
and in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	querioc ory.				
ted nsit	events resulting in death) Last  Due to (or as a conse	quence of):				
and and	The supposed in the supposed i	27 28a-	f,per me,g933 11-	.20_12 am		
box 68760, the death certificate be expt the attending physician ched for use as the burial Physician/Medir	IF FEMALE: 23c. If yes, outcome		1, per me, g, 5, 5, 11	20-12 511	23d. Date of deliver	y
1876 rtifica ing ph as the	23b. Was decedent pregnant in the past 12 months?	2	Fetal death 3 Ectopic	oregnancy	Month	Day Year
ath ce attend attend or use	1 Yes 2 No 9 Unknown   9 Unknown	time of death	Other (Specify)		1	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial confident of the funeral director.	Part II. Other significant conditions contributing to death	but not resulting	in the underlying cause given in Part	I. 23e. Did to	bacco use contribute to	the cause of death?
P.C ss that gned be deta	100 m				2 No 3 Pro	bably 4 🗸 Unknown
Records, The law requires ficate has been sig- page 2 should be				24a. Was a		utopsy findings available completion of cause of
e law e has l				perfor	med? death?	
I Re III The Trifficat or, pag		-	26.Place of Death (C			
Vital ysicians ysicians director		nt 2 🗸 ER/O	utpatient 3 DOA Other4	Nursing Home 5	Residence 6 Othe	er:
Of ng Ph	27. Manner of Death 28a. Date of Inju (Month, Day,Y.	ry 28b.	Time of Injury 28c. Injury at Work?		now injury occurred	
ion trendi death. tror: / the f	1 Natural 5 Pending 2 Accident Investigation fd 11-3		1:10 am 1 Yes 2 X 1			Davida Niverbas City
Division o spital or Attending nours after death eneral Director: Aft filled in by the func	3 Suicide 6 X Could not be determined (Specify)		rm, street, factory, office building, etc.	or Town, S	tate) 201 Wate	ural Route Number, City rsville Rd.
Sapital Sapital Hours		Fd:Resi	<del></del>	Mt.Air		ted
To the He within 24 To the Fu completely	(Check only 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam	y knowledge, de mination and/or i	arn occurred at the time, date and place nvestigation, in my opinion, death occ	urred at the time, date	and place, and due to t	he cause(s)
To the within To the comple	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Me	onth, Day, Year)
	(0)(11801)	6/	O.C.M.E.		November 3, 20	112
	30. Name and address of person who completed cause of d	eath (Item 23a)			<u> </u>	
	Zabiullah Ali, M.D. Assistant Medical Ex	caminer 90	0 W. Baltimore Street, Baltin	nore, MD 21223		
		r's Signature	facel			
Registra	NOV 0 7 2012   Lever	w p.	q			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2-017 Physician/ JAKGON 4 10 M WILLIAM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death\_ 4b. City, Town, or Location of Death **Examiner** BALTIMONE MATIMORE CROMWELL CENTER If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** S. Carolina Months Days Hours 02/27 1940 213-36-6130 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6232 Walther Ave. 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Custodian 5th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည David Jackson Amy Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2435 Keyworth Ave. Baltimore, MD 21215 Joyce Jackson (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 【XCremation 3 ☐ Removal from State 11/8/12 On-Site Crematory | Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral & rivice Licensee 22. Namos Achins of Acility Brown Jr. Funeral Home PA MD21217 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nme late Cause (Final Physician/ ARRIAGENMA CARMAC disease or condition resulting in death) Medical **Examiner** CAN SIO MY O PATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ASCVD attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Dav Yes 2 No ed by the a detached f 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LUNG METAGTA TUI Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) ロヨスモレモ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wo 21234 8710 A

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER JACKSON GERALD Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL RANDAILSTOWN BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month Day Year 11-9-1940 Director 1**X** M 2 □ F MD. 71 Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Gwynn Oak 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7103 Minna Road 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □ X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: African-American 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Office Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lean Jackson Betty Steward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mable C. Jackson/Wife 7103 Minna Road, Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 11-10-2012 Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 Yes 2 Kg completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Denpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🛄 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the hast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Yes State Registrar

DHMH 17 Rev 06-2011

			Please	Type or Print in				_		egible.	
			For	State of Maryla				lental Hy	giene	010	05500
			State     Registrar		Cer	tificate of D	Death		Reg. No.	UIZ	35598
	Physicia Medic		1. Decedent's Name (First, Middle, Las Fred Jone					2. Date of Dea Month Novemb	Davi	ZOIZ	3. Time of Death 11:59 PM
****	Examin		4a. Facility Name (if not institution, give	11			Location of Death		1 1 1	ounty of Death	
	Francis		5. Social Security Number 6. So	1	Sp: †a(	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		out go	hplace (State or Foreign
	Funeral Director			⊠ M 2 □ F	70 <sub>Yrs.</sub>	Months Days	Hours Min.	(Month, Day	y, Year)	Cou	intry)
	M.		Usual Residence of Decedent					05-27-	1942	Sout	h Carolina
	yland f ehc	cto	10a. State 10b. County		City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	e Mer	ië	DC 10e, Street and Number	Was	shingtor	1 10f. Zip Code			45 000	(111 1 0	
	1 end 2 should be filed within 72 hours after death with the Meryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28e-f ehow other traumatic event, the Medical Experience in the notified at	Funeral Director	743 Kennedy Stree	+ NE		20011			USA	n of What Cou	unuye
	ath w	E E	11. Marital Status	12. Was Decedent Ever in	U.S. 13. V		ispanic Origin? (Spe	ecify Yes or No-		Race - Amer	rican Indian.
9	or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No	res? If Yes, specify Cuban, Mexican, Puerto P			Rican, etc.)		Black, White	
ဗ္ဗ	ural",	ē	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2Ã No	Specify:		Spe	ecify: Bla	ck
5-	"nat	e de	15. Decedent's E (Specify only highest gra		(Give		ation during most of work	ing	16b. Kind	of Business/I	Industry
5	ithin i	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		o NOT use retired) Lneer			Gov	vernme	nt
9	Hygl w	Be	17. Father's Name (First, Middle, Last)		28-		18. Mother's Nam	e (First, Middle,			
/lar	d be f denta arked tilc ev	욘	Fred Jones Sr.		Dorothy Ritter						
lan	s should be filed within 72 h and Mental Hyglene. 7 is marked other than "r traumatic event, the Myd		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Tov	wn, State, Zip	Code)
2	end 2 s Health tem 27		Tiffiany Jones/Da				Street NE		_		_
O.	t of H if ite or oth		20a. Method of Disposition 1 (XBurial 2 ) Cremation 3		<ol> <li>Place of Dispo cemetery, crer</li> </ol>	sition (Name of natory or other plac	ce)	Date	20c. Locat	tion - City or	Town, State
Baltimore, Maryland 21215-0036	it. Partumer rtant njury		4 Donation 5 Other (Specif	10.		Cemetery		9/2012			
Ba	permit. Page 1 e Depertment of I Important: If ite any injury or ot		21. Signature of Funeral Service Dicens	50M	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		dover Roa				Home, Inc.
		Н	23a. Part 1. Enter the disease, or com shock, of heart failure. List only o	plications that caused the or	eath. Do not ente					10, 110	Approximate
1	nysician/	, ,	Immediate Cause (Final	M	1.1	-				1	Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (r as a cons		Lhlan	ction Diseas				
	Examiner	ų.	Sequentially list conditions.	b. Corona	ry A	rtery	Diseas	e			
	sit sd	nine	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a cons	equence of):						
10	be executed siclen end burlel-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						
ر 0	s be ex	媡		l d							
Box 68760	ificate ig ph) as th	Med	IF FEMALE:							200-100	· · · · · · · · · · · · · · · · · · ·
Ø ×	h cert tendir or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live Birth 2 F	etal death 3 [	Ectopic pregnand	су		230	d. Date of deli	•
Bo	deet the at hed fo	Physician/Medic	1 Yes 2 No	4 ☐ Pregnant at time of Unknown	of death 5	Other (specify)				Month	Day Year
P.O.	requires that the deeth certificate E been signed by the attending physi should be detached for use as the i		Part II. Other significant conditions c	ontributing to death but not	resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
S, F	ires the signer of the signer	Completed by	Hypertension					1 🗆	Yes 2□I	No 3□Pr	robably 4 Onknown
ord	v requ	lete	17/					24a. Was			topsy findings available
ec	sician: The law certificate has t lirector, page 2 s	E O			·			autor perfo	rmed?	death?	completion of cause of
al F	an: T rtifica rtor, p	BeC	25. Was case referred to medical		-	26. Pf	ace of Death (Chec		2 - 110	1016	2-2110
ξ	ysician: nis certifica I director,		res 2 🗆 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 🗆 DOA Oth	er: 4  Nursing Ho	ome 5 Resid	dence 6 🗆	Other (Speci	ify)
o	or Attending Physician: The law requires thet the deeth certificate Estretor dark.  Inferdor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the I	Certificate:	27. Mann Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	ć?	28d. Describe h	now injury oc	curred	
ši	ttend death stor: A	ţį	2 Accident Investigation 3 Suicide 6 Could not be		home form str		Yes 2 ☐ No	006 Ltion //	Ctoo at a med At	lumbar ar Du	rol Doudo Alumbar
Division of Vital Records,	after after Direction by	Se	4 Homicide determined	building, etc. (Spe	cify)	eet, factory, office		City or Tow		umber or Hui	ral Route Number,
u	To the Hospitel or Attending Phys within 24 brows after death.  To the Funeral Director Affer this completely filed in by the funeral di	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of my kni iner: On the basis of examina	owledge, death	occurred at the time	e, date and place, a	and due to the ca	ause(s) and i	manner as st	ated.
	thin 2, the F	Me		se Practitioner: To the best			the time, date and pl	ace, and due to t	the cause(s) a	and manner a	s stated.
	<b>5.≥ 6</b> 8		255. Oigitatore and the of Certifier	10						Signed (Month	
U	1.		30. Name and address of person who	completed cause of death (H	em 23a) (Tvne I	Print)	01701				.,
	K		George Ho, MD		roll Au	enue, T	Takona Pe	ark, MC	) Z	2091	2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's 2. Date of Death Time of Death Physician/ Month Medical Examiner 4b. City, Town 4c. County of Death If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days M 2 🗆 F Hours Yrs Director 215-78-0219 1959 MD Usual Residence of Deceden 28a-f shov 10a State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3906 Edmondson Ave. 21229 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Tes 2 No Specify. Specify:Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. should be filed within and Mental Hygiene Car Detailer SelfEmployed event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Herbert L. Johnston Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Justice Gilliam traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Johnston (sister) 12 Roman Knoll Ct. Cockeysville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pk 8 201 Baltimore MD 22. Name and Address of Facility
Calvin B. Scruggs
1412 F. Preston S 21. Signature of Funeral Service Licenses Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tree. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of Due to Examiner Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. and that initiated events resulting in death) Last quence of): ed by the attending physician detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 | Yes 2L 9 | Unknown g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ည 1 \( \text{Yes} 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending iniury 2 🗌 No Accident Suicide Investigation To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar title of certifle 29d. Date signed (Month, Day, Year) 0 rson who completed cause of death (Item 23a) (Type, Print) 5 Name and address of pe

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBE Physician/ KLINE MARGIE 05:37AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death nty of Death **Baltimore City Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month Day, Year) 180-28-4394 76 Country) **Director** 1 □ M 2 🗷 F 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Howard **Ellicott City** 1 🗌 Yes 2 🐼 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 4806 Knoll Glen Drive 21043 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ō 21215-0036 1 ☐ Yes 2 M No Specify: White If Yes, Give 'natural", 3 → Widowed 4 □ Divorced Shown L. h and Mental Hygiene.

27 is marked other than "natural" Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) **Administrative Assistant** Lab worker Unknown Be altimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ William Sullivan Aline Dillon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau once, Laura Shilling 201 Brickhouse Dr. Queenstown, MD 21658 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗹 Cremation 3 🗆 Removal from State Atlantic Crematory, LLC Nov 09, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilities, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Lice stondoller NOOS35 23a. Part 1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Subdural Honatama THE THE PROPERTY OF MEDICAL EXAMINER Medical Due to (or as a consequence of) Examiner Fail Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death Yes be detached 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗌 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. Certificate: ☐ Natural ☐ Accident 5 Pending 100 PM 2 No 11/4/2012 1 Yes Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined HOME 4806 Knou Glen To the Hospital within 24 hours To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MD RES-000 NOVEMBER 5 2012 Mh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS BALTIMORE MD 21287 STREET Wan-Ton Chang

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene.

			For State Registrar	State of Maryland /			of Death			Reg. No.	)12	35601			
Physicia Medic			1. Decedent's Name (First, Middle, Last)  RUBY  KEE	-NG					2. Date of De Month	ath O4	2012	3. Time of Death			
	Examin		4a. Facility Name (if not institution, give stre	et and number)  PACKWAY			own, or Location				4c. County of Death  Baltimore				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last to 95		If Under 1 Months	Year If Und Days Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da 3-29-)	th v. Year)	9. Birth	nplace (State or Foreign ntry) MD .			
	Maryland :8a-f shov ntified at	rector	Maryland Baltimore	10c. City, To	own or Loc		Baltimo	re Co	ounty			10d. Inside City Limits 1 ☐ Yes ※※ No			
	s 23a or 2	eral Di	10e. Street and Number 26 Henry Avenue			10f. Zip C	ode 2123	6		10g. Citizen	of What Cou	intry?			
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3√X Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🏋 🗘 No If Yes, Give Year or Dates.			nt of Hispanic C Cuban, Mexic		ecify Yes or No- Rican, etc.)		Race - Amer Black, White cify: Wh				
21215-0036	within 72 hor giene. er than "nat i, the Medica	Comple	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)  College (1-4 or 5+)	(Give ki life. DC	NOT use re	done during mo etired)	ost of work	orking 16b. Kind of Business/Industry  Homemaking→Own Home						
	be filed wi ental Hygiu ked other ic event, t	To Be (	17. Father's Name (First, Middle, Last)  George H. Jacobs	N/A	<u> </u>	omemal	18. Mo		e (First, Middle, Duise Se	Maiden Surn	ame)	own_nome			
, Maryland	d 2 should be file alth and Mental H 27 is marked o er traumatic eve		19a. Informant's Name/Relationship (Type, Print)  Lucille E. Robel (Daughter)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 26 Henry Avenue Baltimore, Md. 21236								n, State, Zip	Code)			
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition  X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	noval from State 20b. Place ceme Balt:	etery, crem	ition (Name atory or othe Nati	er place)	11-9	Date 312		on-Gity or T	ity, Md.			
Balt	permit. Departr Import. any inji		21 Si majure of Funeral Service Licensee	.0	22. 74	Name and A	Address of Fac	ility Las	sahn Fu Ltimore,	neral Md. 2	Home 21236				
	Physician .	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition										Approximate Interval Between Onset and Death			
7	Medical Examiner	<u>.</u>	resulting in death)  Sequentially list conditions, b.												
	ecuted and I-transit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence							1				
094	cate be executed physician and s the burial-transit	edical	d.												
Вох 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and arel director, page 2 should be detached for use as the burial-transi	Physician/Medical	ysician/Me	/sician/Me	/sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	If yes, outcome of pregnancy  1  Live Birth 2  Fetal de:  4  Pregnant at time of death  9  Unknown		Ectopic pre Other (spec					Date of deli Month	very Day Year
s, P.O.	ires that the dea signed by the a Id be detached I	ا ج	Part II. Other significant conditions contri	outing to death but not resulting	ng in the un	derlying cau	use given in Par	rt I.	23e. Did to	- 4		the cause of death?			
Division of Vital Records,	The law require cate has been si page 2 should	Completed							24a. Was autor perfo 1 \( \subseteq \text{Yes}	an 24	b. Were auto prior to co death?	opsy findings available ompletion of cause of			
f Vital	Physician: The this certificate al director, pag	To B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hos  27. Manner of Death	pital:		3 □ DOA		Nursing Ho	me 5 🗆 Resid			ý)			
ion o	Attending F death. ctor: After y the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Ďay, Year)	o. Time of injury	М	Injury at work? 1 ☐ Yes 2		28d. Describe h						
Divis	ital Urs ∭ec		4 ☐ Homicide determined  29a, Certifier 1 ☐ Certifying Physicia	28e. Place of Injury - At home, building, etc. (Specify)  n: To the best of my knowledge				nd place a	City or Tow	n, State)		al Route Number,			
	To the Hospital within 24 hours: To the Funeral completely filled	Medical	(Check 2 ☐ Medical Examiners only one) 3 ☐ Certifying Nurse P  29b. Signature and title of certifier	On the basis of examination and ractitioner: To the best of my kn	d/or investiç nowledge, d	gation, in my death occurre 29c. L	opinion, death ed at the time, o icense number	occurred at date and pla	the time, date a ace, and due to t	nd place, and he cause(s) an 29d. Date sig	due to the cand manner as	ause(s) and manner stated. stated. Day. Year)			
			30 Mame and address of person who com	- MD	a) (Type Pri	int)	7078	5		11/0	5/2	012			
1	3/		DIMITRA MI 31. Date filed (Month, Day, Year)	TSANI 821	N-E	w7Au	SAL.	ST	-308)	BAL	71H0	125 41) 2120			
	Stat Registra	-	NOV 0 7 2012 /2-	32. Regist ar's Signature	Cal										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 2perpHYS, G933, 11/13/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 11-3-2012 Physician/ Month 42 Year <del>2012</del> Noreen Kahn 2:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year) 110-24-4B31 Director 1 🗆 M 2 🖒 F 92 Yrs 12-21-1919 India Usual Residence of Deceden ir than "neturei", or items 23e or 28e-f shov the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3310 North Leisure World Blvd. #901 20906 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 N Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+ Paralegal Law Firm t. Page 1 end 2 should be filed witt tment of Health and Mental Hygler tant: If item 27 is marked other i jury or other treumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abraham Raymond Rachel Gindel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry H. Kahn - Husband 3310 N. Leisure World Blvd., #901, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 11-4-2012 Olnev. Marvland Judean Memorial Gardens 4 Donation 5 Other (Specify) Edward Sagel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1D91 Rockville Pike, Rockville, Maryland 20B52 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiogenic Shock disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): a Hospital or Attending Physician: The lew requires that the death certificate be executed 24 hours affer death.
24 hours affer death.
Perneric Director: After this certificate has been signed by the attending physician end a Funeric Director; After this certificate has been signed by the attending physician end eleipy filled in by the funerial director, page 2 should be detached for use as the burial-transit eleipy filled in by the funeral director, page 2 should be detached for use as the burial-transit Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant a 9 ☐ Unknown 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Conqestive Heart Failure 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Cardiomyopathy 24a, Was an performed? Yes 2 🔀 No Cerebrovascular Disorder 1 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5  $\square$  Pending 1 ☐ Yes 2 ☐ No M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely f 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) 11-3-2012 D0D60634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, MD - 1160 Varnum Street, #021, Washington, DC 20017 31. Date filed (Month, Day, Year) 32. Registrar's Signature State PELKO Registrar 0.00

DHMH 17 Rev 06-2011

35603 Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ **А** М 2012 8:34 Helen Levine Kaufman 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 1616 Featherwood Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months Director 215-44-3833 1 □ M 2 🗓 F 69 Washington, OC Yrs 5-23-1943 Usual Residence of Deceden 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Sant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Ses 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral <del>-28982</del> 20904 1616 Featherwood Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Jewish Council for the Elementary/Secondary (0-12) College (1-4 or 5+) Social Worker Aging. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Selma Arginteanu Jaffe Samuel Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7128 Elk Mar Drive, Elkridge, Maryland 21075 Josh Kaufman - Son permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Clarksburg, Maryland Garden of Remembrance 11-6-2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 Edward Sagel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ Non Hodgkins Lymphoma resulting in death) Medical Due to (or as a consequence of) **Examiner** 4 months Progressive Multifocal Leukoencephalopathy Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) B Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🗓 No |@ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43083 11-3-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sotos, MO - 9707 Medical Center Orive, #300, Rockville, Maryland 20850

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2012

NOV

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00 PM Hugh Smith Knight Jr. October 27,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-32-8050 Director 1 **X**M 2 □ F 76 Aug. 22, 1936 Maryland ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 L Joppa Forest Drive 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Armed Forces?
1 

X Yes 2 □ No If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Lineman Utilities other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Hugh Smith Knight Sr. Lucretia (unk) Monks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Knight / Wife 1400 L Joppa Forest Drive, Joppa, Maryland 21085 f Health item 27 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 1 🗌 Burial 2 🛛 Cremation 3 🗍 Removal from State Rose Hill Svcs. LLC 11/6/2012 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. execut weaver 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ Athero disease or condition resulting in death) Medical Examiner UNKROWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown LISCA 340Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural I or Attending F after death. 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours at within 24 hours a

To the Funeral C

completely filled Medical sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practice: It To the best of my knowledge, death occurred at the time, date and blace, and due to the cause(s) and manner as stated. 29a. Certifier (Check and title of certifier Mper Chosapeake who completed cause of death (Item 23a) (Type, Print) Andrew I hot 31. Date filed (Month

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 18:18 M Physician/ Day Year 2, ZOIZ Kathryn Lynn Kane Jovenber Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Country) Texas Director 162-46-0838 1 □ M 2 □ F 60 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filad within 72 hours aftar daath with tha Maryiand Director X Yes 2 No MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 838 Highland Road USA 21154 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ģ 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Glen Stewart Doris Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Dapartment of Haalth ar Importent: If Item 27 is eny Injury or other trau Palmer Kane / Husband 838 Highland Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial X ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/5/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorola Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 50 scleretic Physician/ disease or condition resulting in death) Medical UNKNOWN Due to (or as a consequence of): disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exam use as the buriai-transit Tha law raquires that tha daath cartificata be exacutad Due to (or as a consequence of): resulting in death) Last Aftar this cartificate has bean signed by tha attanding physician funarai diractor, paga 2 shouid be datachad for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No oteatri? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this compiataly filled in by the funaral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 142 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053568 November 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV 0 7

November

sousea

Bal Am MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. state of Maryland Department of Health and Mental Hygiene For State Registrar 35606 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 MORTON LARMER NOVEMBER 08:30A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOMERFORD PLACE HOWARD COLUMBIA Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours Director 215-22-4900 1 🔀 M 2 🗆 F 84 09/15/1928 Usual Residence of Deced MD show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD HOWARD 1 Yes 2X No COLUMBIA 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 8220 SNOWDEN RIVER PARKWAY 21045 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working EMPLOYEE RELATIONS is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DIRECTOR OF BALTIMORE COUNTY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ပ BENJAMIN KLASMER SADIE SAKOLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 and 2 s Health tem 27 BETHANY WISHNER/DAUGHTER 5123 CRYSTAL PARK LANE, permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t ELLICOTT CITY, or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other ANSHE EMUNAH - AITZ CHAIM 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/05/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (i Examiner Sequentially list conditions, Examine cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of, that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 2 9 Unknown ed by the a Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? 1 Yes 2 Who death? 1 🗌 Yes 2 🗆 No filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? within 24 hours after death. To the Funeral Director: A ☐ Accident ☐ Suicide 2 No Investigation 6 Could not be

completely

Hospital

State Registrar

Medical

31. Date filed (Month, Day, Year, NOV 0 7 2012

4 Homicide

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed of

determined

SHARLATA

use of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

331

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day 4, 2012 8:30 AM BLOSSOM KAHN Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Director 109-18-4157 1 🗆 M 2 💢 F 88 Usual Residence of Decedent 03/09/1924 NY th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, t<u>he Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2609 GAGE COURT 21209 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ドチドン おしのSSOM Baltimore, Maryland 21215-0036 Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 🖾 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATOR WHOLESALE COFFEE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ DAVID ROSSMAN HATTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. SUSAN SEROTTE/DAUGHTER 7915 SHERWOOD AVENUE, BALTIMORE, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH DAVID 11/06/2012 ELMONT, NY 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part 1. Enter the diseas 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition Physician/ Hemorrha Medical resulting in death) Examiner rombocyto unknown TENIG Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit months kemia Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month g Unknown 9 Unknown certificate has been signed by irector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Mannef of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 725 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brescia - Oddo 6701 N. Charles St 31. Date filed (Month, Day, Year) Degistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7, 10f, per FH, G933, 11/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Viola Boone Lewis Month 28 7:25a 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris- Dulaney Valley Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) 85 Yrs. Director 212-26-2776 1 ☐ M 2 ☐XF MD 12/04/1927 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hyglane. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28a-f show any injury or other treumetic event, the Medical Examiner mast be partified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 XYes 2 No Baltimore 10f. Zip Code 21216 21212 ۵ 10e. Street and Number 10g. Citizen of What Country? 2749 Winchester Street U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 7:25 а.ш. 1 Yes 2 XNo Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker BB 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harrison Boone Etta Bannister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OCTOBER 26, Deborah L. Smith (Daughter 4009 N. Rogers Ave. Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State Garrison Forest 11/5/2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of run Service Licensee 22. Name and Address of Facility Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Balto., MD 21217 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sicien and buriel-transit Due to (or as a consequence of): resulting in death) Last attending physicien I for use es the burle Physician/Medical Hospitel or Attending Physicien: The lew requires that the deeth certificate be P.O. Box 68760 VIOLA LEWIS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) ad by the a ∐Yes 2 😿 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pege 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? 1 Yes 2 No After this certificate funerel director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 😿 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No To the Hospitel or Attending within 24 hours efter deeth.
To the Funerel Director: Afte completely filled in by the fun 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: In the basic of examination and/or investigation in a stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) NOV 0 7 2012 32. Registrar's Sanature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ EAN 12:25 Рм 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HAVEN NURSING FOREST If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yea 1933 Maryland **Director** 217-30-6408 1 □ M 2 🗓 F 79 Oct. Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at Director 1 X Yes 2 □ No Maryland Baltimore Catonsville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21228 701 Edmonson Avenue United States items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Not Applicable Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Pauline Cadle Truman Lippy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Lower / Cousin 405 Boyer Nursery Road, Biglerville, PA 17307 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20a. Method of Disposition 20c. Location - City or Town, State November X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8, 2012 Frederick, Maryland 21. Signature of Funeral Service Licen Keeney and Sastord PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List/ omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit RONARY the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A No this certificate 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Dother (Specify) 2 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 1 X Natural Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15503

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 7 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE MO 21217

AMATUN N NAEEM, 501 DOLPHIN STREET, BALTIMORE MO 21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29,2012 Month **Physician** FLOYD LE.

4a. Facility Name (If not institution, give street and number, TOBER /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🛛 M 2 🗆 F 03/15/1937 75 Ohio 219-33-3433 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Dundalk 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a or USA Funeral 56 Portship Road 21222 permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any Injury or other traumatic even. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Yes 2 X No 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) <u>Automotive</u> 10 Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tarqueeno Lucile ပ Floyd Lemmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 56 Portship Road, Dundalk, MD 21222 Zaroni Lemmon / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/05/2012 Hanover, Maryland 4 TXDonation 5 Other (Specify) Anatomy Gifts Registry 21. Signatu of Funeral Service Lice see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ATHEROSCHEROTIC VASULCHI **Physician** ECUTE COROHARY disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of The law requires that the death certificate be executed nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate has 2 No 1 🗌 Yes 2 🗌 No 1 TYes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical director, Be examiner? Hospital: 1 | Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred funeral 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ours after death. eral Director; Afte filled in by the fur 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hour To the Fune completely fi 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0063303 OCTOBER 29,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 RODICA 31. Date filed (Month, Day, Year) State 2012 7 Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death O Z Physician/ LISTENBEE 8:45PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STEWA MARIS TIMONIUM BAUTIMORE If Under 1 Year If Under 24 Hrs.
Page Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 327-28-5924 Director 1 🕅 M 2 🗆 F AK 10d. Inside City Limits 10c. City, Town or Location death with the Maryland or than "naturel", or items 23a or 28a-f sho Director 1 X Yes 2 □ No MD BAUTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral Gerland AVENUE 21206 USA 5500 Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: If Yes, Give Year or Dates other than "naturel", 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Vulcan Hart 12 Maintenance permit. Page 1 and 2 should be filed w Depertment of Health and Mental Hygi Importent: If item 27 is marked othe eny injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Su isten BEE DRNEMA Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Green. BROTHER Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 MR Removal from State Homewood, 1L 11-10-12 Washington Menory 4 ☐ Donation 5 ☐ Other (Specify) NOVEMBER 22. Name and Address of Facility Vaugha GReene Funerar Services 21. Signature TFuneral Service Licensee Road. Baltimore, MO. 21212 NO1553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BLADDER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events attending physician and I for use as the burlel-trar LISTENBE Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown WELBIE Month Day 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has I autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔣 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) မ 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 30. Name and address of person who comple ause of death (Item 23a) (Type, Print)

State Registrar TRACIE L.

31. Date filed (Month, Day, Year)

MORGAN.

CRNP

2. Registrar's Signature

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Morningside House Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 184-20-3511 86 1 □ M 2 🛣 F May 14,1926 Marion Heights Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Old Harford Road 21234 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 XNo
If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Social Security marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roman Rugalla Cecilia Simchock and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Carolyn Buck-Daughter 2810 Andrea Avenue Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 s Department of H Important: If ite any injury or ot November Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other Druid Ridge or other place Baltimore, MD 4 Donation 5 Other (Specify) 7,\_ 2012 Signature of Funeral Service Licensee Evans fundral Chapel & Cremation Services 8800 Harford Road Parkville, MD 21234 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. I nediate Cause (Final dinease or condition Onset and Death Physician! Medical resulting in death) **Examiner** Sequentially list conditions, if any leading to immediate Examine if any leading to immediately included to the cause. Enter Underlying Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Unknown ed by the Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2. No 1 🗌 Yes Be ( Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) State

C DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5Day Physician/ William T. Lafevers NOV. 20<sup>4</sup>2 6:30 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Towson Gildhrist Hospice Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 216-36-3326 1X M 2 □ F 74 Jan. 16, 1938 North Carolina Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Seat: If Items 229 or 28a-f show eart: If Items 27 is merked outher then "naturel", or Items 23e or 28a-f show ury or or other traumetic event, its Medical Examination must be notified at ury or orther traumetic event, its Medical Examina 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2XX No Maryland Harford County Jappa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2909 Woods End Drive 21085 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Specify: White Completed 3 Widowed 4 Divorced al Hygiene. d other then "nature event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Employee Bethlehem Steel 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Creed Lefevre Faye Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2909 Woods End Drive, Joppa, Maryland 21085 Marjorie Lafevers (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other p Evans Funeral Chapel 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Importent: If It eny Injury or o 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/07/2012 Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 NO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Fnysician/ Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, Sequentiary its containors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ettending physicien and I for use es the burlal-transit or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month been signed by the e should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes t director, page 2 s autopsy performed? 1 🗌 Yes 2 🗆 No Q funeral director, Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes ٩ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Horp' 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 21 death. 1 🗌 Yes 10/22/2012 21 No unknowl t t Investigation s efter deat 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 2909 Wood ENC JGDPQ, MO ZIO85 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours Medical 29a. Certific Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 9b. Signature and t 29c. License number 29d. Date signed (Month, Day, Year) W.D D0071287 pleted cause of death (Item 23a) (Type, Print) - \* 4105, Baltimore State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2032 M 31 Year naries aymar 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medical ( University Baltimore, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 129-22-4095 Director 1 XM 2 F Apr. 1, 1925 New York 87 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Harford Bel Air 1 Yes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 1120 Spaulding Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 XYes If Yes, Give 2 No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Vice President Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Mae Auten Floyd (unk) Layman and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health an tant: If item 27 is 1120 Spaulding Drive, Bel Air, Maryland 21014 Shirley Layman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) t o = 9 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or Druid Ridge Cemetery 11/5/2012 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Maryland Sign Func Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. W 50 W. Broadway, Bel Air, Maryland 21014 dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part 1. Enter the disease, or complication Interval Between et and Death shock, or heart failure. List only one call Immediate Cause (Final Physician/ Subdural disease or condition resulting in death) hemovrhage Medical Due to (or as a consequence of) Examiner MINICATION APPROVED BY WE DEAL EXAM Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for selectorescuence of requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Box 68760 attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown signed by t. Id be detach Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Hypertension 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Dislase 24a. Was an • Hospital or Attending Physician: The law v 24 hours after death.
• Funeral Director: After this certificate has b. certificate has b lirector, page 2 s autopsy performe 1 Yes mpletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury work? 5 Pending 2 👿 No 10/31/12 Unknowin Fall Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1120 spaulding Drive, Bel Air, MD Home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complet 29b. Signature and title of 29d. Date signed (Month, Day, Year) 1720303811 31 2012 KAY MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 GREENE Baltimore 54

Registrar

DHMH 17 Rev 06-2011

State

7 2012

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (1) Physician/ 1:31am James E. Lowery Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, Year) 217-18-4661 Director 1 2 M 2 □ F 88 7/23/1924 Maryland Usual Residence of Decedent ir then "naturel", or Itams 23a or 28a-f ehow the Medical Evanther must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD 1 Yes 2 X No Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 800 Four Seasons Road 21157 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 hours efter 1 ☐ Yes 2 XNo Specify White Specify: Completed 3 Widowed 4 Divorced res, Give Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ai Hygiane. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Machinist Metal Fabrications parmit. Pege 1 and 2 should be filed w Department of Heelth and Mental Hyg Important: If Item 27 is merked othe any injury or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Charles B. Lowery Hazel Fear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Lowery, Jr. Son 800 Four Seasons Road, Westminster, Maryland 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State 11/6/2012 Meadowridge Mem. Pk ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signative of Funeral Service Licensee Hubbard Funeral Home, Inc. 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician NYONIL disease or condition mont Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Hospital or Attending Physicien: The iew requires that the death certificeta be executed ettending physicien and I for use es the buriai-transif Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the elid be detected f 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? the illuta 24a. Was an this certificata hes rai director, pege 2 autopsy perform Lance U19 1 Yes 2 No Division of Vital After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) HES/14 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after deeth.

To the Funerel Director: Afte completaly filled in by the fun Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medicai 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 ٥ rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 12012 Physician/ UANET LEATHERMAN 0415AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 210-28-5562 Hours 1 🗆 M 2 🖺 E 75 Director Feb 14, 1937 Pennsylvania Usual Residence of Decedent in than "naturel", or items 23a or 28e-f show the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hedgesville WV Berkeley 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25427 Funeral 20 Conservative Lane USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "naturel", or ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours efter 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F. 7 is marked of ည Mary Eliza Beal Frank Earl Yauger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pege 1 and 2 sh Depertment of Health ar Importent: If Item 27 is eny injury or other trau 20 Conservative Lane Hedgesville, WV Michele Davis Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11-6-12 Smithfield, PA Mt. Moriah Cemetery 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee Metropolitan Funeral Service 22. Name and Address of Facility VA 22310 5517 Vine Street Alexandria, part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami Hospital or Attending Physicien: The law requires that the death certificate be executed physicien end is the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as attending plant of for use as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death 5 Other (specify) Year ed by the a g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ြို 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fu ☐ Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES-000 NOVEMBER 1 2012 on who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS ST BALTIMORE MD 21287 nonzalez State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 936 PM M ALEYANDER 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL CENTER BALTIMORE 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign last birthday, **Funeral** Sex 1 M 2 □ F (Month, Day, Hours 49 **Director** 0033 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director Examiner must be notified 1 Yes 2 No timore 10e. Street and Number 10g. Citizen of What Country? ō Funeral 23a permit. Page 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. "Important if item 27 is marked other than "natural", or items any injury or other traumatic event the Market. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ d (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🙏 🚓 35 19a. Informant's Name/Relationship (Type, Print) 9 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c ocation - City of Town, State 1 🗆 Burial 2 🖫 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee neval Home, P.A. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, ast only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician at be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by RENAL 1 Yes 2 No 3 Probably 4 Unknown ANJAIC Records, Completed cate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (DALVLOPATHY autopsy perform 1 ☐ Yes 2 🗷 No 124 hours after death. E Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Division of Vital 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 10 25

Registrar DHMH 17 Rev 7/2009

State

315

30

2012

2120 1

MD

31. Date filed (Month, Day, Year)

NOV O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2-06344 Nason Andrew Lee,	
	1- For State Certificate of Death Reg. No.  1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Physician/ Medical Examiner	Mason Andrew Lee Jr. November 4, 2012 1223 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1717 Glen Curtis Road 4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 2.15 80 5543   1 N 2 F   51
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State
Physician Notical Examiner	21 Signature of Funeral Service Licensee  22 Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.
). Box 68760, the death certificate be executed the attending physician and ched for use as the burial - transit Physician/Medical Examiner	☑ UNPENDED ☐ AMENDED 23a,pt.II,27,28a-f,per me,g933 11-16-12 sm
Records, P.O. E  The law requires that the c ficate has been signed by th page 2 should be detached Completed by Ph	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated.  29b. Signature and ditle of certifier  20c. Prace of Death (Intex chill) one) 1 DOA  Other4 Nursing Home 5 Residence 6 Other. Scene  28d. Describe how injury occurred unknown  28f. Location (Street and Number or Rural Route Number, City or Town, State) 1717 Glen Curtis Rd.  Essex, MD.  28f. Location (Street and Number or Rural Route Number, City or Town, State) 1717 Glen Curtis Rd.  Essex, MD.  29c. License number  O.C.M.E.  O.C.M.E.  November 5, 2012
State Registrar	A MI AAIA MA
OCA = 0000	ODINE ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death \_aver Physician/ November 1, 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITO 7. Age (In yrs. last birthday) altimore 十 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 182-74-3890 19 Director 1 □ M 2 🔀 F 11/26/92 Spain Usual Residence of Decede 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The marked other than "natural", or items 23a or 28a-f show often 72a marked other than "natural", or items 25a to 28a-f show often trainmitic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA Telford Bucks 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Bartlett Court 18969 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student Student Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) စ္ James Finley Laverty Wendy Nanette Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Bartlett Ct Telford, PA 1889 James Finley Laverty, father 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)
Atlantic Crematory 11/6/12 20c. Location - City or Town, State permit. Page 1 and Department of I mportant: If ite any Injury or of 1 Burial 2X Cremation 3 Removal from State Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman Funeral Service PA 7221 Gravburn Dr Glen Burnie MD 21061 21. Signature of Fu eral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hetastatic Chordoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Who
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 2 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD November 1, 2012 empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 100 cansst. Baltimore, MD 21287 8 Wan-Tsu Chang 31. Date filed (Month, Day, Year) State 7

DHMH 17 Rev 06-2011

Registrar

P.O. Box 68760

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20 1<sup>Year</sup> Physician/ LESLIE CHARLES LEE 7:30A November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 220-30-5465 1 **X** M 2 □ F **Director** 78 Yrs 05/31/1934 Maryland Usual Residence of Decedent "naturai", or items 23a or 28a-f show odical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2XX No Freeland Maryland Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21053 25 Timbershed Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2XXNo Specify If Yes Give Specify. 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "1" once. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Senior VP Banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret McNeal Leslie George Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Timbershed Court Freeland Maryland 21053 Sally Kearns Lee Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parkwood Cemetery 1 XX Burial 2 Cremation 3 Removal from State 11/08/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fachit tchell-Wiedefeld Funeral Home Inc nature of Funeral Struct Licen 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Netastatic colorectal cancer outh disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 901 C 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 24 hours after death.

Funeral Director: After this etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0070635

State Registrar

DHMH 17 Rev 06-2011

Suite 4105

Baltmore, MD 21204.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

Pate

aura 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17, per 1h, g934 12-6-12 sm
State of Maryland / Department of Health and Mental Hygiene 3562 Reg. No U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 2:20 AM JAMES LEWIS 10 27 20/2 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Iown, or Location of Death BALTIMORE NIA FUTURE DLDSPRING If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 F 218-44-5282 Director uaust Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Director Himae 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21231 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☐ No Specify. Specify: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) actor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Hallie Lewis ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1 eborah 412 N. ewis MI watt more Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State a HMDO MI 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility nera Due MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DIOMYOPATH LHEMI Medical Due to (or as a consequence of) Examiner ARDIO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit YSPHAG Due to (or as a consequence of) Physician/Medical Box 687 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. s been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 N Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy , page perform STROKE certificate 2 **X**No Division or Vital 1\_ To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Monument of State of After this of funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death. To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO73354 2012 1n.0 TTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7Hm.n 8813 WALTHAM WOODS RD #204 PARKUILLE MD 21234 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

AMEND PI LINE B-C PER MD G933 11/8/12 TRT Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 1/5/12 trt State of Maryland / Department of Health and Mental Hygiene amend #206 Per FH G933 11/07/2012 Mental Hygiene Certificate of Death Reg. No. Amend #25, per ME G933 1 - For State 35622 Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept Year Physician/ 13:22 dired 2017 Mood Medical 4c. County of Death 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death Examiner University of Mariland Medical Center Baltimore If Under 1 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs 6. Set 7. Age (In vrs. last birthday) **Funeral** Months Min. (Month, Bay, Year) 1 Country) Hours MD 1 Director 1 □ M 2 💢 F 61 -52 - 46Yrs 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director notified Yes 2 No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or ner must be n ō U.S.A. Funeral 21230 1301 Washington Blvd Apt A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 5 þ 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Black 1 ☐ Yes 2 ▼No Specify: "natural" 3 Divorced 4 Divorced Completed Medical 16b. Kind of Business/Industry Baltimore City Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools the Assoc. Instructional 12th grade 5vrs+ permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maisie Horsey William Moody Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 1301 Washington Blvd, Baltimore, Md Wade McLaughlin-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/06/2012 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, Md 10/8/2012 New Catheral Donation 5 Other (Specify) 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, 21. Sign tu e of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Baltimore, Md 21215 Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** CERTIFICATION APPROVED BY METERN EXAMPLES MYOCARDIAL INFARCTION Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed STROKE and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Vinknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No certificate Yes 2 3 Vital 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 26c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Division within 24 hours after death To the Funeral Director: A Accident Investigation filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 29d. Date signed (Month. Day, Year) 29b. Signature and title of 29c. License number 1063788842 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Omoyemi South Greene Street, Baltimore, MD 21201 Hdebayo 31. Date filed Month, Day, Year) Registrar's Signature State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35623 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Buford Matthews :12 AM 2012 NOV Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland 1educal Len Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept 23 1936 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral Birthplace (State or Foreign Country) Days 527-42-5592 76 Director 1X M 2 □ F ALPILIO: -,
Page 1 and 2 should be filed within 72 hours are. ......
tment of Health end Mental Hygiene.
trant: if Item 27 is marked other then "naturel", or Items 23e or 28a-f show
rtant: if Item 27 is marked other then "naturel", or Items 2.20 or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Eldersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 21784 10g. Citizen of What Country? 1800-A Vincenza Drive Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1958 Black, White, etc. 1 Never Married 2 Married **全** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 1964 Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 10 OMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Matthews Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800-A Vincenza Dr., Eldersburg, MD 21784 Mrs Joan Mary Matthews (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 D Burial 2 Cremation 3 Removal from State 11-13-12 4 Donation 5 Other (Specify) Garrison Forest Vet. Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final nterstitial Disease Physician una disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 14 years ancer in Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dua to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death cate has been signed by the signed by the signed 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Disease autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 🗆 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) four Eles CRNP 2012 NOV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lou-Ellen Lallier South Greene Itimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 \_ State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kenn 1250 2012 Novem Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Randallstown Chapel Hill Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye 9-6-1925 217-26-0661 Director 1 🗆 M 2 🔀 F 87 VA Yrs show ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🕅 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 USA 4511 Robosson Road ral", or items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important if item 27 is marked other trainment any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: Yes, Give SpecifyAfrican-American 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Homemaker Domestic 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. McKenny/Son 1688 Sunberry Ct., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD matory 11-8-2012 Baltimore, M)
22. Name and Address of Facility VILE Fun-ral Home P.A. of Palto. Co. Signature of himeral 2 rv e Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ به حدا Medical resulting in death) Due to (or as a consequen **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician: The law requires that the death certificate be executed burial-trar that initiated events Box 68760 resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. á signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 5No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending Matural 1 injury 1 Yes 2 No Accident
Suicide the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

NOV 0 7

Registrar

DHMH 17 Rev 06-2011

of death (Item 23a) (Type, Print)

MD

3. Registrar's Signature

037573

2613

29d. Date signed (Month, Day, Year)

Salubour

November 6,2012

amend 19b. per fib. 933, 11-26-12 sm ype or Print in Black indelible jnk. Ensure All Copies Are Legible. Per FH G933 10/0//2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month McIntyre 6:30p.M Charles 2012 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 3610 Denmark Place Bowie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours Min. 219-22-2757 Director 1 Å M 2 □ F 12 01 28 NC 83 Usual Residence of Decedent ir than "neturei", or items 23a or 28e-f ehow 10a State 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3623 Columbus Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 Black 1 ☐ Yes 2 K No Specify: 3 Widowed WD Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pege 1 end 2 should be filed within 72 ment of Health end Mentel Hyglene. ent: if item 27 is merked other than 'ury or other treumetic event, the Menuy or other treumetic event, US Dept of the Elementary/Secondary (0-12) College (1-4 or 5+) Army <u>Cinlian Police</u> 10 th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Katrina Marable Charles T. Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Baltimore, Bowie 3610 Denmark Place, Kevin McIntyre-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 Depertment of I 1 X Burial 2 Cremation 3 Removal from State importent: if eny injury or 11/5/2012 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge aunature of Funeral Service Licensee March F/H west 4300 Wabash Ave, 21215 Baltimore, Μđ 23a. Par 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician NOW SMa disease or condition resulting in death) Month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760  $^{\circ}$ IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 The Sidence 6XX Other (Specify) Residence 1 ☐ Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Registrar DHMH 17 Rev 06-2011

0

State

29a. Certifier only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6569

N.

82. Registrar's Signature

MI

(GNG

NOV 0 7 2012

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 35626 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31 2012 Physician/ OCTOBER 9:25 A M MCGOWAN BRUCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 11577 DUNLORING UPPER MARLBORO 6. Sex 1 A M 2 A F If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Social Security Number **Funeral** Hours Min MARCH 13 LOUISIANA Vrs 1963 437-15-2438 **Director** 49 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director notified 1 

Yes 2 □ No 28a-f MD PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code pe 23a Funeral with USA 20774 11577 DUNLORING DRIVE must death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. o. 1 Never Married 2 X Married à hours after Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working within 72 and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the PRIVATE 12th MEAT CUTTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Department of Health and Mant. Important: If item 27 is marked any injury or other transmones. ANDREWNETT MCGOWAN BOBBY EARL SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CASSANDRA MCGOWAN/WIFE 11577 DUNLORING DR. UPPER MARLBORO, MARYLAND 20774 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 11/7/2012 CLINTON, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Larson 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NONISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** HYPERTENSION Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Duis to (unas a consequence of be executed ATRIAL FIBRILLATION and -trans that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 requires that the death certificate attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Year in the past 12 months? Day Month Pregnant at time of death the 9 Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERLIPIDEMIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 2 No Hospital or Attending Physician: The 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) rector, Be Hospital Other: 2 No မှ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After X Natural 5 Pending injury work?
1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29d. Date signed (Month, Day, Year)

State

Registrar

29b. Signature ar

Date filed (Month, Day, Year)

NOV 0 7 2012

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Thomas Maslem MD 7525 Greenway Center Drive #312 Greenbelt, Maryland

D55559

11/2/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Aston Charles Martin 2012 8:00A Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5105 70th Avenue Hyattsville Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Date of Bill. (Month, Day, Yes (an. <u>26</u>, 1 **X** M 2 □ F Year **Director** 578-06-0391 <u>Jamáica</u> 78 Jan Usual Residence of Decedent 10a. State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Prince George's Hvattsville 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? be Funeral ral", or items 23a Examiner must b 5105 70th Avenue 20784 Jamaica Page 1 and 2 should be filed within 72 hours after death \u00famment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gerald Martin Margaret McMoren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsa Martin/Wife 5105 70th Avenue Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2012 Silver Spring, Maryland Gate Of Heaven Cem. Signature of Fureral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. attacker 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 7474 Landover Road Hyattsville, MD Approximate Interval Between Physician Metastatic Adenocarcinoma of Stomach disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760<sup><</sup> as the IF FEMALE: Jse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy or Attending Physician: The law requires that the death for in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.0. ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) Fremelles 20058213 November 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q Farhad Jamali MD 12150 Annapolis Road #308 Glenn Dale, Maryland 20769

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year) NOV 0 7 2012

artel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ McGugan Month 0750 2012 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Annapous, Mr Anne Arunde Center 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 143-44-5671 1 🛛 M 2 🗆 F Usual Residence of Deceder 61 Dec. 16. 1950 Pennsylvania or 28a-f shov 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Crownsville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1059 Omar Drive 21032 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry est grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) United States 4 Electrical Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Raymond McGugan, Sr. Salome Greatrex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Margaret K. McGugan / Wife 1059 Omar Drive Crownsville, Maryland 21032 20b. Place of Disposition (Name of cemetery, crematory or other place)
Epiphany Episcopal
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 Donation 5 Other (Specify) 9, 2012 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.
1411 Annapolis Road Odenton, Maryland Will Eddonen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ METHSTATIO 6WEEK Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month ate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr this certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ဍ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie only one 29h Signature 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

			Please amend #11	Type or Print in I Per FH C933 11 State of Marylan	Black J	ndelible Ink	. Ensure A	II Copies	s Are	Legible.		
		_1	For State Registrar	State of Waryian		rtificate of D			Reg. No.2012 35629			
	Dharista		Decedent's Name (First, Middle, La	est)	ī			2. Date of Dea	th Day Year T			
	Physicia Medic	al .	- 0:12	MANCE	JP.			29	1 3015	12026W		
4	Examin	er	4a. Facility Name (if not institution, give	_	<b>~</b> \	4b. City, Town, or I			County of Death			
	Funeral			Sex 7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign	
	Director		- 1	10M2 0 F 6 Z	Hours Min.	(Month, Day	y, Year)	19 /1) Cour	1:1 >			
	wor.	-	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		02/01,	1-1		10d. Inside City Limits	
	aryiar	ecto	MD P.G.			NSVILI	<b>%</b>				1 Yes 2 ☐ No	
	the M	ᄒ	10e. Street and Number	190	1010	10f. Zip Code			10g. Cit	tizen of What Cou	intry?	
	deeth with the Maryland Items 23e or 28e-f show	Funeral Director	3415 GREET	NUASTLE RE		208	0 0		-	SA		
			11. Marital Status  12 Mever Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spa n, Mexican, Puerto	cify Yes or No- Rican, etc.)	l	14. Race - Ameri Black, White		
036		d by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		1 ☐ Yes 2 ☑ No	Specify:		1	Specify: B	-ACK	
5-0		ig i	15. Decedent's (Specify only highest g		16a. Dece	dent's Usual Occupa kind of work done du	tion uring most of work	ina	16b. K	and of Business/I	ndustry	
21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. L	OO NOT use retired)		•	US	SA GOU	م المالين	
d 2	ied within 7 Hygiene. other then	l oo l	17. Father's Name (First, Middle, Last)	<u> </u>		PEN	18. Mother's Nam	e (First, Middle,				
lan	fentel fentel rked tic ev	잍	Ciptis MANCE	Se.			Annahe	ile C	cle	MAN		
Maryland	1 end 2 should be filed within ' f Heeith end Mentel Hygiene. Item 27 is merked other ther othsr treumetic event, the M		19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ing Address (Street a					Code) 20910	
	1 end 2 s if Heeith item 27 othsr tr	П	HOLY CROSS		150					JER SR	@M 242	
Jor	ige 1 entof h	Н	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3	Removal from State	emetery, cre	osition (Name of matory or other place	9) .	Date		•		
Baltimore,	permit. Page 1 e Department of H Importent: If ite eny injury or ot	H	4 ☐ Donation 5 ☐ Other (Spec		dare	2. Name and Addres	ame and Address of Facility  Ly M. Wallace Fugeral Service  Manufact					
B	Depar Impo eny ir	Н	Maurin.	Eselve	3	HOSE W. FRA	AllACE FLIA	end Bar	timo	RE MAIL	uland	
			23a. Part 1. Enter the disease, or cor shock, or head failure. List only	mplications that caused the deat one cause on each line.	h. Do not en	ter the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
1	nysician/ Medical	H	Immediate Cause Final disease or condition resulting in death)	a SICKLE	CEL	L DIST	EASE				Onset and Death	
4	Examiner		resulting in death)	Due to (or as a conseq	uence of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):							
	executed en end riei-trensit	Examiner	Cause (Disease or injury that initiated events	c								
_	se exe icien e buriei-	I— I	resulting in death) Last	Due to (or as a conseq	uerice oi).							
200	cete t phys	ğ		d								
Box 68760	requires that the death certificate be ex been signed by the ettending physicien should be deteched for use as the burie	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	v		- 1	23d. Date of del	,	
<b>B</b> 03	the ett	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of Unknown	death 5	Other (specify)			Month Day Year			
P.O.	requires thet the been signed by ti shouid be detech	F	Part II. Other significant conditions	contributing to death but not re-	sulting in the	underlying cause giv	en in Part I.	23e. Did 1	tobacco	acco use contribute to the cause of death?		
S, F	uires ti signi uid be	P P	ACUTE RE	IA7 JAUS	LUV	CE		1 🗆	Yes 2	es 2 No 3 Probably 4 Wunknown		
ord	iew requ	Bet	CARDIONY	PHTA901				24a. Was				
Rec	The peg	Ĕ	THROMBOC	YTOPENIA					ormed?/	death?	2 🗆 No	
tal	sicien: The certificete irector, peg	Be	25. Was case referred to medical examiner?	Hospital:		26. Pla	ace of Death (Chec	k only one)				
Ť	Phys this reid	<u>ا</u> ۾	1 ☐ Yes 2 ☑ No  27. Many of Death	1 1 Inpatient 2 2	ER/Outpati 28b. Time	ent 3 LI DOA	4 ☐ Nursing H	ome 5 Resi		6 ☐ Other (Spec	ify)	
o Lo	tending P deeth. tor: After t the funer	Cate	1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	injury	work						
Division of Vital Records,	r Atter er dee rector	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28s Place of Injury At h		treet, factory, office		28f. Location (	Street ar	nd Number or Rui	ral Route Number,	
ē	To the Hospitel or Attendi within 24 hours after deeth To the Funerel Director: A completely filled in by the f										atod	
)	Hosp 24 ho Fune etely	Medical	(Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination curse Practitioner: To the best of	on and/or inve	stigation, in my opinio	on, death occurred a	at the time, date	and place	e, and due to the	cause(s) and manner stated.	
	Vithin To the comp	2	29b. Signature and title of certifier		,	29c. License				ate signed (Monti		
			* AN	- m.s.		Dbb:	249		10	,30,2	.012	
	3 W		30. Name and address of person who				805 0	Mal in	N	S.S.H	D 20910	
	Sta	te.	31. Date filed (Month, Day, Year)	JURAN ME 3. Registrar's Signa	ature		EST 6	LXN Ve	_VV	7.3.11	20 110	
	Registr		NOV 0 7 20	112 12	5 h.	a del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 9:31 November Cora Virginia Moore Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 7 Glenwood Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 219-18-0747 1 M 2 F Feb. 1, 92 1920 Maryland Usual Residence of Deced ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 XX Yes 2 No Harford Maryland Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13 Roland Place 21014 USA or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", White 3 □ Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Federal Government Security Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret Virginia Coleman permit. Page 1 and 2 should be Chester Edward Burtt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 Glenwood Road, Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trauonce. Horace A. Moore / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion UMC Cemetery 11/8/2012 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign any of Fun / Service censee 50 W. Broadway, Bel Air, Maryland 21014 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Part 1. Enter the disease, or compli Interval Between Onset and Death shock, or heart failure. List only on Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Ducito (or as a so and burial-trar that initiated events Due to (or as a consequence of resulting in death) Last g physician as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: ase a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy signed by the atter in the past 12 mg 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 ■No 3 □ Probably 4 □ Unknown page 2 should Were autopsy findings available 24a Was an autopsy performed prior to completion of cause of death?

1 Yes 2 No After this certificate has the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA Residenc 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director; Af Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) Signature and title of certifie

State

BOLAIMA 21015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or I halday

170d

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2012 Juanita Montgomery 9:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 931 Candlelight Court Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 214-24-1486 Director 1 M 2 1 F 90 Dec. 17, 1921 Virginia Usual Residence of Decedent il Hygiana. I other than "natural", or Itams 23s or 28s-f show vent, the Madical Examinar must be notified at 10b. County 10c. City, Town or Location flied within 72 hours after death with the Maryland Director Maryland Harford 1 ☐ Yes 2 🔀 No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 931 Candlelight Court 21015 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Narried Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Paga 1 and 2 should be filed.
Department of Health and Mantal Hwmportant: If them 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Abraham Matlock Josie Ethel Kinser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ken Montgomery / Son 4870 Harford Creamery Road, White Hall, MD 21161 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Removal from State
4 □ Donaron 5 □ Other (Specify) Bel Air Memorial Gdn. 11/7/2012 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. M 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani FND STARE ase or condition Medical Due to (or as a consequence of) Examiner HYDECT YEARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the dasth certificats be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranelt ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ My ucardizinfarction, glavcoma Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? carota vtenovir 24a. Was an autopsy 1 ☐ Yes 2 1 No 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nonth V 6:15 PM Mildred Marenka Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hanes DA HIMOI N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 214-60-1276 Director 1 □ M 2 🗓 F Sept 6, 1917 96 Yrs Pennsvlvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 732 S. Beechfield Avenue 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harrison Katherin Urban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 S. Beechfield Avenue Baltimore, MD 21229 Michael Marenka, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 11/05/12 21. Signature of Funeral Service Licensee **Tho**mas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ulmondy disease or condition Medical resulting in death) <sup>/</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an his certificate has t autopsy performed Yes 2 2 🗀 No 1 Tes ivision of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 4NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours and To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 00063534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton AVR, Baltimore, MO 21229

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a623PIT Per PHY C934 12/10/2012 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. Physician/ 2012 1:05 AM Frank Martin. Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Blakehurst Health Care Center Towson 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours Months Davs 577-26-0709 Director 1 **X** M 2 □ F Sept. 17, 1918 Maryland 94 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f shoventy injury or other traumatic event, the Medical Examinar must he matified at 10d. Inside City Limits 10b, County 10c. City, Town or Location Director 1 Yes 2 No Towson **Baltimore** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21204 United States 1055 West Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Armed Forces?
1 ☑ Yes 2 ☐ № 1941–45 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Balto. Gas & Elec. 12 Gas/Steam <u>Maintanence</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bigelow Frank Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21204 1055 West Joppa Road, Towson, <u>Virginia Martin (Wi</u>fe) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/1/2012 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. Signature of Funeral Service License Stephanie Custer Catonsville, Maryland 21228 Frederick Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Coronary Artery Disease Immediate Cause (Final Physician/ 134 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury Hospitel or Attending Physician: The lew requires that the death certificete be executed ate has been signed by the ettending physiclen and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cor Pulmonale 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? History of Recent Urosepsis 24a. Was an autopsy performed? Yes 2 No Dementia After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. CRNP-BIAKEHUVST SHARON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1055 24, JOPPA RUAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar / DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) Physician/ MO Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>3517 Edwards Lane</u> Middle River
Under 1 Year | If Under 24 Hrs Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Hours Country Director 212-22-1378 1 M 2 □ F 6/6/1926 Yrs. Maryland 86 Usual Residence of Deceder th and Mantal Hygiana. 27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10b. County within 72 hours aftar daath with tha Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3517 Edwards Lane United States 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1943 1 ☐ Yes 2 ☐XNo Specify: If Yes. Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) 12 National Security Agency Department of Defense Be Page 1 and 2 should ba filad ment of Haalth and Mantal Hy ant: If Item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William John McKay, SR Claire Tlasek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Haalth a t: If Item 27 is or other tra Elizabeth Anne McKay (Wife) 3517 Edwards Lane Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date parmit. Page 1 a
Dapartment of H
Important: If Ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /9/2012 of Faith Mem. Overlea, Maryland Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Thrombosis Physician/ REBRA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of): Examir the attending physician and ched for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No cata has baen signed by the atter paga 2 should ba datached for Month of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribate to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 1 the funaral director, 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Matural Division within 24 hours aftar death, To the Funeral Director: A complately fillad in by the fo 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 20+1

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** mber 3,2012 sernaro /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)

June 20, 1931 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ XM 2 □ F Maryland Director 214-26-6810 Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code items 23a or 21237 U.S.A. 8100 Rossville Blvd. 333-A Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X□ Yes 2□ No If Yes, Give Year or Dates: Korean 72 hours after or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: <u>م</u> 3 Widowed W Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Sun Papers 8 Years Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked o Ethel A. Lowman James H. Mol1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7709 Buck Hill Road Kingsville, Maryland 21087 Department of Health a Important: If Item 27 is any injury or other trainonce. Theresa A. Brown (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 innent of He 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/8/2012 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. Middle River, MD 21. Signature of Funeral Service Licensen Michael Neiser 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY **Physician** AILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ON GESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): LSCHEMIC IOSA Due to (or as a consequence of): attending physiciar Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 Probably ♦ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1-4-Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred filled in by the funeral Certification: Division 5 Pending investigation Injury 1 Yes 2 No s after death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide or A 24 hours 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

Registrar
DHMH 17 Rev 1/2001

State

OPIGII

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANDACAK

7 2012

KAOUL

31. Date filed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

November 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 November 9:38 PM Arthur John Maas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Greenbelt 5 Ridge Road Unit F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Year) 15, 1918 Days Hours Canada Director 367-12-6236 Mar 1 🔀 M 2 🗆 F 94 in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Greenbelt tX☐ Yes 2☐ No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 20770 USA 5 Ridge Road Unit F 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: 3₺ Widowed 4 Divorced Year or Dates. 1941-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public Junior High History Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Meilicke John Valentine Maas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Ridge Road Unit F Greenbelt, MD 20770 Jeanne Esther Maas/daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 11/07/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Beverly L. Clarksville. 21029 MO1251 Heckrotte. P.A. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo |₽ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural I Director: A 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours af

To the Funeral Di

completely filled in Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, November 5, 2012 29c. License numbe D47654 Weensus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Charlotte Dean, M.D. 110 Irving Street 6 B10 Washington DC 20010

32. Registro's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ November Barbara Ann Machine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltimore Sinai Mosbital Baltimore 01 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) ocial Security Number Funeral Country) Maryland Months Davs Hours Min. (Month, Day, Year) 01/06/1933 1 □ M 2 🗡 F Director 216-28-9709 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No **Baltimore** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **USA** 21234 7821 Hillsway Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Machine, Barbara 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Gerbert Steve Baltimore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Machine / Husband 7821 Hillsway Avenue, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 11/4/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dor<u>ota Marshall</u> Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VO Caro day disease or condition resulting in death) Medical sequence of) Due to (or as a 🌶 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-trensit and that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 2 No 1 ∐ Yes 215 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 🌃 ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 2, 2012 altimore 2401 W. Belvedere Ave. Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mv Mosb Hal of B HOODA inai 31. Date filed (Month, Day, Year) NOV 0 7 2012 32. Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar				Cen			Death			Reg. No.	012		
Physici	_	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 9:16													
/Medio Examir	-	4a. Facility Name (If not institution, give street and number)  4b. City, 1					City, Town, or Location of Death  BEL ATR					4c. County of Death HARFORD			
Funeral Director		5. Social Security Number 212–05–2982	6. Sex	7. Age	9 (In yrs. Ia	st birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 8-7-1	iy, Year)	9. <b>M</b>	Birthplace (Stai	e or Foreig
inyland		Usual Residence of Decedent 10a. State 10b. Con	unty		10c. City,	Town or Loc								10d. toside	City Limi
with the Maryland a or 28a-f ehow	Irecto	MD.  10e. Street and Number	BALTO.			BALDW	IN 10f. Zip	Code				10g. Citiz	en of What		
death	by Funeral Director	2922 PLACID  11. Marital Status  1 Never Married 2  3 Widowed 4 Divo	12. Married	Was Decedent B Armed Forces? 1 Yes, Give		IF	Vas Deced Yes, spec	dent of Hi cify Cuba	21013 ispanic Ori in, Mexicar Specify:	gin? (Spec n, Puerto R	cify Yes or No lican, etc.)	1		American Indian Vhite, etc.	,
ad within 72 he glane. er than "netur , the Macical	Completed	15. Dece (Specify only hi Elementary/Secondary (0- 9TH	edent's Educat ighest grade of		i+)		ent's Usu- kind of wo DO NOT u	rk done d se retired	during mos ()	t of workin		16b. Kind of Business/Industry  HOME			
es 1 and 2 should be filed world health and 2 should be filed world Hygier I fem 27 is marked other ir other traumatic event, Ibs	To Be	17. Father's Name (First, Mic JAMES G. MII 19a. Informant's Name/Rela	LLER	Print)		10b Mailin	a Addross	(Street	TH	ERESA	GOLDE  Route Numb	BECK		te Zin Code)	
Permit. Pag Department Department Important: f on y injury o		20a. Method of Disposition  1	er (Specify) Licensee	tions that caused cause on each lir	GAI	. Do not ente	OF FA Name ar 610 V	AITH and Addres	ss of Facili	11-7- SCHI IL RO	MUNEK AD BE	BAL' FUNE	TO. MI	OME, OF 21014 Approxi	BEL
bath certificate be executed by attending physicien and for use as the burial-transit	lan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	d	Due to (or as  Due to (or as	a consequence of pregnar 2 ☐ Fetal	ence of):  ence of):  ence of):	Ectopic p	regnancy	m G E			2	23d. Date of Month	f delivery Day	Year
eath certificate be executed attending physicien and Ifor use as the burral-transit	Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnan	d	Due to (or as  Due to (or as  Due to (or as  ti yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a conseque a conseque of pregnar 2 Fetal time of de	ence of):  ence of):  ence of):  ence of):  ency death 3	Ectopic p	regnancy pecify) cause giv	,	l.	1 🗆 24a. Was	tobacco u Yes 2	Month se contribu No 3 [ 24b. Wer	Day  Inte to the cause  Probably 4  The autopsy finding of the completion	of death
eath certificate be executed attending physicien and Ifor use as the burral-transit	e Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnamenthe past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions of the past 12 months?	d 23c	Due to (or as  Due to (or as  Due to (or as  ti yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a conseque a conseque of pregnar 2 Fetal time of de	ence of):  ence of):  ence of):  ence of):  ency death 3	Ectopic p	regnancy pecify) cause giv	ren in Part		1 🗆 24a. Was	tobacco u Yes 2 s an opsy ormed? 2	Month se contribu No 3 [ 24b. Wer prior deal	Day  Inte to the cause  Probably 4  The autopsy finding of the completion	of death?
eath certificate be executed attending physicien and Ifor use as the burral-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnament the past 12 months? 1	d	Due to (or as  Due to (or as  Due to (or as  ti yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	a conseque a conseque a conseque of pregnar 2 Fetal time of de ut not result    YYRO	ence of):  ence of):  ence of):  ence of):  ency death 3	DEctopic p Other (s) Inderlying of	regnancy pecify)  cause giv	26. Plac	e of Death ursing Hon	1 ☐ 24a. Was auto perf	tobacco u Yes 25 s an oppsy ormed? 257No one)	Month use contribut Alto 3 [ 24b. Wer prior deal 1 [	Day  te to the cause Probably 4  re autopsy finding to completion th? Yes 21 No	of death?
or Attending Physician: The law requires that the death certificate be executed fred death.  First death.  First death.  First differ this certificate has been signed by the attending physician and no by the tuneral director, page 2 should be detached for use as the burral-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1	adical Hose ending vestigation ould not be elemined	Due to (or as  Due to (or as  Due to (or as  Lif yes, outcome 1	a conseque a conseque a conseque a conseque of pregnar 2 Fetal time of de ut not result for the consequence of the consequence	ence of):  ence of):	DEctopic p Other (s)  Inderlying of the second of the seco	regnancy pecify)  cause giv  OA Oth Oth O28c. Injur U y, office	en in Part  26. Plac  er: 440 N  y at  k?  Yes 2	e of Death ursing Hon 2 3 No	24a. Wasautc perf 1 Yes (Check only ne 5 Res 28d. Describe	tobacco u Yes 25 s an ppsy ormed? 2 No one) sidence ( show injur (Street an wn, State	Month  Se contribu  No 3 [  24b. Wer prior deat 1 [  6 [Other (  y occurred  d Number (  ))	Day  Ite to the cause Probably 4  The autopsy finding of the completion of the compl	of death?  Unknowngs availaged cause
eath certificate be executed attending physicien and Ifor use as the burral-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnament the past 12 months? 1	adical Hose ending vestigation ould not be etermined	Due to (or as  Due to (or as  Due to (or as  Lif yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  buting to death b  HYP677  spitat: 1 Inpatie 28a. Date of Inju (Month, Da	a conseque a conseque a conseque of pregnar 2 Fetal time of de sur not result (*Y / R *D*)  and 2 fetal time of de sur not result (*Y / R *D*)  and 2 fetal time of de sur not result (*Y / R *D*)  and 2 fetal time of de sur not result (*Y / R *D*)  and 3 fetal time of my known of examination	ence of):  ence of):	DEctopic p Other (s) Inderlying of the standard of the standar	regnancy pecify) cause giv  OA Oth 28c. Injur Wor 1 y, office	26. Plac  26. Plac  er: 44 N  y at  k?  Yes 2	e of Death ursing Hon 2 ] No	24a. Was autoper 1 yes  Check only ne 5 Res 28d. Describe 28f. Location City or To	Yes 25 s an ppsy ormed? 25 No one) sidence (Street anown, State e cause(s), date and	Month  Se contribu  24b. Wer prior deal 1	Day  tie to the cause Probably 4  re autopsy finding to completion th? Yes 2  Specify)  or Rural Route er as stated.	of death?  Unkno ngs availa of cause of cause.

Please Type or Print in Black Indelible Ink./ Fingure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 2, 2012 Physician/ 12:05 A.M Denise Michelle Magner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2XXF Director 214-74-4743 Sep. 2, 1951 61 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho Director Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 814 West 34th St. 21211 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examinations. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ 1 Yes If Yes, Give 1 ☐ Yes 2XXNo Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Music Performance Musician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Main Joseph Lawrence Magner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 Church Rd., Owings Mills, MD 21117 Bernice Magner (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Eremation 3 Removal from State S. Carroll Crematory 11/9/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature et Funeral Saus-Ucent 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Mau am 11605 Reisterstown Rd., Owings Mills, MD 21117 First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small cell carcinona, UNKnown netostatic Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 M/No
9 Unknown Month Day Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NWS PLO 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or invertigation in my applied to the cause (s) and manner as stated.

within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

Registrar

DHMH 17 Rev 06-2011

State

29a. Certifier

(Check

Signature

AARON

31. Date filed (Month, Day, Year)

d title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M) 32 Registrar's Signatur

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ST TONION MO

November 2 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla		partment of He e <i>rtificate of De</i>			2011	2 35640			
	Dhusisis		Registrar  1. Decedent's Name (First, Middle, Last,			ortificate of Be	Jatiri	2. Date of Deat	_	3. Time of Death			
	Physicia Medic		Seymour J	Hiller	-			Month	3 ZO	12 0945#			
	Examin	er	4a. Facility Name (if not institution, give s	meet and number)	111	4b. City, Town, or Le	ocation of Death	(C)	4c. County of Death				
	Funeral	91	5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. E	Birthplace (State or Foreign Country)			
	Director	į	220-01-0878 1 P	IM 2 L F	93 Yrs.	Michael Suy		027047	1919	MD			
	rland f show d at	tor	10a. State 10b. County	10c. (	City, Town or	Location				10d. Inside City Limits			
	e Man r 28a- notifie	Jirec	MD N/A	I	BALTIMO					1 🏋 Yes 2 □ No			
	with th	Funeral Director	6317 PARK HEIGHT	S AVENUE, #5	15	10f. Zip Code 21215			10g. Citizen of What ( USA	Country?			
	items			2. Was Decedent Ever in Armed Forces?		B. Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		nerican Indian,			
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at , the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🏖 No		,	0 1/	HITE			
Maryland 21215-0036	hours hatur dical E	Completed	15. Decedent's Edi (Specify only highest grad	cation		cedent's Usual Occupati		na	16b. Kind of Busines				
12	thin 72 ene. than ' he Me	mo.	Elementary/Seconday (0-12)	College (1-4 or 5+)	life.	DO NOT use retired)		ng	HCED	CARS			
0	be filed wi ental Hygie ked other ic event, ti	Be	17. Father's Name (First, Middle, Last)			OWNE	8. Mother's Name	e (First, Middle, N		CARS			
ylar	ild be fill Mental narked o	မ	MORRIS		MILLE	R	ROSE	COHEN					
Mar	2 should th and Me 27 is marl traumati		19a. Informant's Name/Relationship (Typ		14	illing Address (Street and							
	and Heal tem (		J. SALLY MILLER/  20a. Method of Disposition	20b	. Place of Dis	position (Name of			20c. Location - City	ORE, MD 21215 or Town, State			
m 0			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			rematory or other place) MEMORIAL PA	:	/2012	RANDALLS	STOWN, MD			
Baltimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service License			22. Name and Address	of Facility SOI	LEVINS	ON & BROS., INC. PIKESVILLE, MD 21208				
			23a. Part 1. Enter the disease, or compleshock, or hear failure. List only one	cations that caused the de	eath. Do not e					Approximate Interval Between			
Arrio,	Physician/	Y d	Immediate Cause (Final ) disease or condition	Chrona	ru F	triory [	Liocas	l		Onset and Death			
	Medical Examiner		resulting in death)	Due to (or as a conse	equative of):	OSCHILLOW	- Anni	NAnt					
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
0	certificate be executed anding physician and use as the burial-transit	edical E	Testiting in death) Last	Dae to (or as a const	squeriec oi).								
8760	ificate ng phy as the		IF FEMALE:										
89 X	ith cert	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg	etal death 3	Ectopic pregnancy			23d. Date of o	1			
Box	he death y the atte	Physician/M	1  Yes 2 No 9 Unknown	4 Pregnant at time of Unknown	of death 5	Other (specify)			Wildit	Day 10a			
P.0	law requires that the death certific nas been signed by the attending s 2 should be detached for use as	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the	e underlying cause giver	n in Part I.			to the cause of death?			
Records,	equire	Completed								Probably 4 Unknown			
eco	rsician: The law I s certificate has b lirector, page 2 s	dmo						24a. Was a autops perfori	sy prior t med? death				
a H	ian: Th	Be	25. Was case referred to medical examiner?			26. Place	e of Death (Check	1 Yes	2,L/No 1 L 1	∕es 2 □ No			
Ξ	ding Physician: h. After this certific funeral director,	유	1 Yes 2 No	ospital:			4 W Nursing Ho		ence 6 Other (Sp	ecify)			
0 0	nding I tth. : After e funer	cate	1 2 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time injury	work?	es 2 🗆 No	28d. Describe ho	ow injury occurred				
Division of Vital	r Atter ter dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec					f. Location (Street and Number or Rural Route Number, City or Town, State)				
á	pital o		29a. Certifier 1 Certifying Physic			h accurad at the time d	ate and place on			ntatad			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Dedical Examin	cian: To the best of my kno er: On the basis of examinat Practioner: To the best of	tion and/or inv	estigation, in my opinion,	death occurred at	the time, date an	nd place, and due to th	e cause(s) and manner stated.			
_	Vithi Volta		29b. Signature and title of certifier	Λ.	C. O.A. W	29c. License n	umber	2	29d. Date signed (Mo	nth, Day, Year)			
	Im 1		30. Name and address of person who co	ROLLY (1	<u> </u>	- his	2888		1012	114			
	, 11,		Sheria Farrell-S	eavey 910	em 23a) (Ţype	perty Rol	Randai	istown	, mp 2	1133.			
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NOV 0 5 2012	32. Registrary Sign	nature Jack	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pay 2012<sup>ea</sup> November 4 12:23P DOLORES MUNDAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Min. Days (Month, Day, Year) **Director** 217-14-3509 1 □ M 2**X X** F May 12, 1921 Maryland Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Columbia 1 - Yes 2 XXVo Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with USA 6210 Woodleigh Drive 21044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. If Yes, Give Year or Dates Specify: 3XXWidowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker e 1 and 2 should be filed wit of Health and Mental Hygle If item 27 is marked other ir other traumatic event, 牡 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew John Hummer Ella Rodney permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 910 Wellington Road Baltimore, Maryland 21212 Sharon M. McIntire 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 XX) Burial 2 Cremation 3 Removal from State Parkwood Cemetery 11/09/2012 |Baltimore, Maryland 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Acure fubrilar mercisis Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner nephroscieroses pertensin Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or an a consequence of). physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 5 Other (specify) 4 Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $mathbb{M}$  Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director After completely filled in by the fun Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one and title of certifier 29d, Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARON S MANUER 701

Registrar

State

31. Date filed (Month, Day, Year)

NOV 0 7 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2: 17 PM Physician/ JOYEM BER YELYN 02 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOOD IMORE If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. las Funeral Hours 214-72-1463 54 Director 1 □ M 2 🗓 F MD 6-11-58 Usual Residence of Deceden 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c City Town or Location Director Anne Arundel 1 Yes 2 X No Baltimore MD 10e. Street and Number 10f, Zip Code 10a. Citizen of What Country? 21225 USA 3912 Brooklyn Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ò ò 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. "natural", 3 Widowed 4 X Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nursing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dorothy W. Kinder John Arthur Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 Brooklyn Ave. Baltimore MD 21225 Department of Health a Important: If item 27 is any injury or other tra Darlene J. Marshall/sister f Health 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 11/3/2012 Catonsville MD Metro Crematory 4 ☐ Bonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Home 21061 22. Name and Address of Facility Kirkley-Ruddick 421 Crain Hwy SE Glen Burnie MD M01364 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 123 SI ESPI disease or condition resulting in death) Medical (or as a consequence of **Examiner** Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death
Unknown signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate has 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DCA မ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAWI

ABIX

NOV 0 7

31. Date filed (Month, Day

Year)

0

3001 S. HANOVERST, BALTIMORE

JOYEMBER 02, 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:05 P.M WIDBER 2012 BERNARD RICHARD MYERS SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SOUACE BALTIMORE ROSEDALE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 218-40-2548 1 XXM 2 □ F Yrs 68 APR. 6 1944 MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10d Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No **BRADSHAW** MARYLAND BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21087 12046 PHILADELPHIA RD. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. \$ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SELF CONSTRUCTION 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN COUPLIN CAMPBELL MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Broadneck Crossing Rd., Edgewood, Md., 21040 Bernard Myers Jr. / Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donyttion 5 ☐ Other (Specify) METRO CREMATORY 11-07-12 BALTIMORE, MARYLAND Summer of Funer Service WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S. PHILA. BLVD, ABERDEEN, MD., 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month 4 Pregnant at time of death ned by the at detached for 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ CANCER Records, 1 Yes 2 No 3 Probably 4 Unknown Completed CARDIO MYOPATHY, NON ISCHEMIC 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed TACHYCARDIA VENTRICULAR this certificate 1 ☐ Yes 2 ☐ No : After this certifical to funeral director, p 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3666310 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 STUART R. WILLES M.D. FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

12-08329 Tammy Faller

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tammy Faller	1	State - For State	e of Marylan		artment of		d Menta		20	12	35641
Physiciar	7/	<b>Registrar</b> 1. Decedent's Name (First, Middle,La	ast) Fatima					2. Date of De	eath	3.	Time of Death
Medical Examin	er	r Fatima Bernadette Jacqueline Neal November 4, 2012									0431 hrs
		4a. Facility Name (if not institution, g Johns Hopkins Hospital	ive street and numb	per)		4b. City, Town, or Baltimore	Location of I	Death	4c. County	of Death	
Funeral	4		Sex 7.	Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Under 2	24Hrs. 8. Date of 8	Birth (MM/DD/YYY)	9. Birthpl	lace (State or
Director			м 2[Х] ғ	3 ( )	41 Yrs	Months Day	s Hours	Min. 06/1	0/1971	Foreign Countr	ry) MD
	H	Usual Residence of Decedent									
w any	ſ	10a. State 10b. County MD	N/A		Town or Locat						Od. Inside City Limits Yes 2 No
yland -f sho	ខ្ន	10e. Street and Number	11,21			10f. Zip Code			10g. Citizen of W		
or 28s	Director	1701 W. Baltin	more Sti	reet		101. 2.10 0000	21223	3	-	S.A.	
D 21215-0036 should be filted within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Deced					? ( Specity Yes or I	No- 14. Race	e - American	n Indian, Black,
death or iten	Funeral	1 X Never Married 2 Marrie	1 Yes	es? 2 X No	lf Y			uerto Rican, etc.)		e, etc.	,
safter	ᇗ	3 Widowed 4 Divorce  15. Decedent's Education (Specity	or Dates:	completed)	1	Yes 2 X No		nd of work done	Specify:	Bla usiness/Indu	
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4		during m	ost of working life	DO NOT us		Andrev	v & A	ASSOC.
036 thin 7; than fedical	톍	9th			Prope	rty Mar			Real I		.e 
21215-0036 Jud be filed within 7 I Mental Hygiene. I mered other than it event, the Medical	ខ្ញ	17. Father's Name (First, Middle, La			-			Name (First, Middle		*)	
121 Id be f Mental market	Be o	Charles R. Ne			19b. Mailin	Address (Stree	et and Numbe	er or Rural Route N	umber. City or Toy	vn, State, Zi	ip Code)
2 shour and N	٩	Sharon Casey-	Bost (Mo	other	) 837	N. Patt	cerso	n Pk. Av	re. Bal	to.,	MD 21205
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ı	20a, Method of Disposition  1 Burial 2 X Cremation	Removal from	- 1	Place of Dispos crematory or ot	sition (Name of ce her place)	metery,	Date	20c. Location		
Pages bent of		4 Donation 5 Other Spe		O:				11/6/12			e, MD
Balti permit. Departi Import		21. Sign sture of Funeral Service Lio	ensee	$\geq$	22.1	Joseph	s of Facility	rownJr	. Funer	al Ho	ome PA 0 21217
Physician	1	23a. Part I, Enter the disease, or cor	nplications that cau	sed the death	n. Do not enter t	2140 N he mode of dying	, such as care	ton Ave	arrest, shock, or he	eart	Approximate Interval
/Medical	1	failure. List only one cause on	each line. a. Intrace								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co			ildo with	0010	2000			
	ا ۾	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence o	of):					_	
	틝	cause Fine Hodedvino Cause	C.								
d d ansit	<u>Ж</u>	events resulting in death) Last	Due to (or as a co	onsequence o	or <i>)</i> :						
O, e be executed sician and burial - transit	dical Examiner	X UNPENDED	X AMENDED#1	,23a,2	27,per 1	ne,g936	2-6-13	sm			
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou						23d, Date o		y Year
Box 68760 e death certificate the attending physical for use as the bu	Physician/M	past 12 months?	1 Live birt	h nt at time of de	anth -	etal death 3 ther (Specify)	Ectobic b	pregnancy	Month	Day	i eai
ות ש מידו	ļ.	1 Yes 2 No 9 V Unkno	5 Officion					las s		- 1 - 1 - 10 - 10 - 1	
Records, P.O. Box  The law requires that the deati cate has been signed by the att page 2 should be detached for	당 라	Part II. Other significant condition	s contributing to c	leath but not i	resulting in the	underlying cause	given in Part		tobacco use cont res 2 No 3		bly 4 🗸 Unknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death.  Tal Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detached in by the funeral director, page 2.						-		24a. W			osy findings available
tal Records cian: The law requi certificate has been	Completed							pe	rformed?	death?	npletion of cause of
Rec a: The luffcate or, page		25. Was case referred to medical				26.Plac	e of Death (C	1 ✓ Ye heck only one)	s 2 No	1 🗸 Yes	2 No
Vital   hysician:	8 2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ing	patient 2	ER/Outpatien	t 3 DOA	Other <sub>4</sub>	Nursing Home 5	Residence 6	Other:	
n of ding Ph.  After tl		27. Manner of Death	28a. Date of (Month, D	Injury Day,Year)	28b. Time of	·	ury at Work?	1	e how injury occur	Ted	
ivision or Attend after death. Director:	뜷	2 Accident Pending Investig	ation	of Injury At h	ama form atro		Yes 2 N		n /Street and Num	her or Rural	Route Number, City
Division  Division  pital or Attent  ours after death  teral Director:  filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determine	ot be	or trijury - At i	lome, laim, sue	et, factory, office	banang, etc.		n, State)	201 01 T(GILI	Troute Hallberry City
)) ,		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowled	dge, death occu	erred at the time, o	late and plac	e, and due to the ca	ause(s) and manne	er as stated.	
To the Hospita within 24 hours To the Funeral completely fills	Medical	one) 2 Medical Examin	ner:On the basis of and manner sta	examination a	and/or investiga	ition, in my opinio	n, death occu	rred at the time, da	ate and place, and	due to the c	cause(s)
	ž	29b. Signature and title of certifier	1/2	20			se number .M.E. ປ	UNIC	29d. Date sign		
101		Therdree Me	6-6	JEGA	4.4	,   0.0	.WI.E. U	Unic	November		
Pan		<ol> <li>Name and address of Mrson wh Theodore M. King, Jr., N</li> </ol>				900 W. Baltin	more Stre	et, Baltimore,	MD 21223		
Sta	ite	31. Date filed (Month, Day Year)		istrar's Signal						w.	
Registr	ÆΠ	NUVU (2)	UIG Buch	un 1	1. Jana						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Yea</sup> November 8:15 A. Charles F. Nierintz Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 4106 Charbonnet Drive Jarrettsville If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye) Feb. 10, Days Director 1939 Pennsylvania 200-30-0681 1 1 M 2 □ F 73 ir than "natural", or Itams 23a or 28a-f show the Wedical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Pennsyl<u>vania</u> Chester Elverson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 96 Caernarvon Drive 19520 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Paga 1 and 2 should be filed within 72 hours aftar Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mantal Hygiana. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Communications Specialist Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Cecelia Bentley Charles Nierintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Nierintz / Son 96 Caernarvon Drive Elverson, PA altimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1 s
Dapartment of H
Important: If Its
any Injury or ot 5 2012 1 Burial 2 Cremation 3 Removal from State Evans Tuneral Chapel Nov. Forest Hill, Maryland 4 Donation 5 Other (Specify) Air 21. Signature of Funeral Service-Licensee Evans Funeral Chapel & Cremation Service—BelAir Da 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Artoniosc disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be datached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy l or Attending Physician: Tha i aftar death. Director: Aftar this cartificata h 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 □ No Other: 4 | Nursing Home 5 | Residence 6 N Other (Specify) Friends Lama မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 8 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Notice Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I unity until 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Der12012 completed cause of death (Item 23a) (Type, Print) Month, Day, Year, State Registrar

DHMH 17 Rev 06-2011

V

R

(eru

es

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NICOLAUS ILLIAM 01 37 A M NOVEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. **Director** 1 🗙 M 2 □ F 215-40-3974 MARYLAND 69 -14-1943 or than "netural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours aftar daath with the Maryland al Hyglena. 1 other than "netural", or items 23a or 28a-f sho 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits MD. BALTO. ROSEDALE 1 Yes 2 X No ۵ 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 7912 OAKDALE AVENUE 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever III U.S. Armed Forces?
1 ☑ Yes 2 □ No
If Yes, Give
Year or Dates. 1963–1967 Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Completed Specify: 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRESIDENT AFT parmit. Pege 1 and 2 should be filed wit Depertment of Health end Mantal Hygier important: if item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ GEORGE W. NICOLAUS DORIS MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7912 OAKDALE AVENUE ROSEDALE, MD. 21237 BONNIE NICOLAUS SPOUSE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Donation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 11-8-2012 GLEN BURNIE, MD. . Signature of Funeral Service (censes) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastalic gastroes phasar disease or condition Medical resulting in death) Due to (or as a consulur nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for se a consequence of אויטוחg physician end usa es tha buriei-trensit Due to (or as a consequence of): resulting in death) Last Aftar this cartificata has baan signad by tha ettanding physician funarai director, paga 2 shouid ba datechad for usa es tha burie Physician/Medical To the Hospital or Attending Physician: The law requires that the death cartificate be swithin 24 hours after deeth.

To the Funerei Director: After this cartificate has been signed by the ettending physicial compietally filled in by the funeral director, page 2 should be deteched for use es the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_\_1 ☐ Yes \_2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Nystaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 NOVEMBER 42012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hibba - Ful Rehman . 1800 DRIEANS 1800 DRLEANS BALTIMORE MD 21287 31. Date filed (Month, Day, Year) State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perINF, 6933, 11/13/2012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Offer 2012 Nov. 9:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2948 Edgecomb Circle North Baltimore Social Security Number 215–08–9624 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) Months Hours Country) Director 1 □ M 2 🗓 F MD 11-02-68 43 Yrs Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Vedical Examiner must be notified at 10a. State 10b. County be filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 2948 Edgecomb Circle Nosth **USA** 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. African 1 K Never Married 2 Married Completed by Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) NA Ouest Diagnostics Phlebotomist 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame)

OFFER Be 17. Father's Name (First, Middle, Last) EARNESTINE ည **GEORGE** OFFER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4532 Finney Avenue Baltimore, Maryland 21215 19a. Informant's Name/Relationship (Type, Print) Farnestine Offer-Mother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Date 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State Catonsville, MD 11-03-12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PERTENSIVE CARDIOVASCULAR disease or condition Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Pnysicien: The last completely the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 41EPATITIS Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 N **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇰ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death assumed at the cause (s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) MD 02-2012 005 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER REISTERSTOWN, MD 21136 UMA 210 DRIVE 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Oliver Physician/ Month No V Maria ,Darlena, 2012 18:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) Director 180-44-3335 1 ☐ M 2 🛣 F 59 Dec. 10, 1952 Pennsylvania Usual Residence of Decede or then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Laurel Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20723 9763 Lady Slipper Court, #1B hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specily: White Completed 3 Widowed 4XXDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Ingram Entertainment 12th Order Processor e 1 end 2 should be filed wit of Health end Mental Hygle If item 27 is marked other in other treumetic event, to Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Flanigan George Zuberbuehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Bowman/Companion 9763 Lady Slipper Court, #1B, Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Department of H Importent: If ite eny injury or otl 1 Burial 2 Cremation 3 Removal from State 11/9/2012 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 21. Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 23a. Part 1/Eyter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Post Obstructive Pneumonia Pmysician/ disease or condition resulting in death) uce.K Medical Due to (or as a consequence of): Examiner years Small Cell Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physicien: The lew requires thet the death certificate be executed ng physicien and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 < Completed by Physician/Medical for use as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Year signed by the e 9 🔲 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ✓ Yes 2 □ No 3 □ Probably 4 □ Unknown To the Hospitel or Attending Physicien: The lew requires within 24 hours after death.

To the Funerei Director: After this certificate has been six completely filled in by the funeral director, page 2 should I Chronic Obstructive Pulmonory Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performe 2 N **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti poo62273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Amin

31. Date filed (Month, Day, Year)

Howard County General Huspital 5755 Cedar Lane, Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 3. Time of Death Physician/ 09:20 AM O'Neill V. 2012 Ctoper Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 219-18-5672 1 [] M 2 K F 08/24/1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8654 Cobscook Harbour 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Tes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland 12 Employment Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robinson James Whaley Fannie Ι., 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health er Important: If Item 27 is eny Injury or other trau Mr. Patrick J. O'Neill / Son 8654 Cobscook Harbour Pasadena, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park: 11/05/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Signature of Funeral Service Licensee MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheno Clenosis Physician/ Cardio Vascular diseas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OPT Sequentially list conditions, Examine Due to (or as a consequence of): Tany, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physician and for use es the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery signed by the etter in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown After this certificate hes been si funeral director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 No 24 hours after death.

Funeral Director: After this certifica letely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဍ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0073466 tospital drive Clen burnie mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAGORERT 301 31. Date filed (Month, Day, Year) NOV 0 7 Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ Oliver Elizabeth Jean 5:10 Ά November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Center Towson 8. Date of Birth (Month, Day, Year) . Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 212-42-5371 Director 1 □ M 2 🛣 F 69 May 10, 1943 Usual Residence of Decede 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 121 North Belnord Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes. Give Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9 years Banking Accounting Clerk Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Edith Kelly James West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Main Sail Court, Middle River, Maryland 21220 James Oliver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) NOVEMBER 1 Burial 2XXCremation 3 Removal from State BayviewCrematory 5, 2012 BAltimore Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Connelly Funeral Home of Dundalk, P.A. 711) Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): be detached for use as the burial-transi the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu OLIVER IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 1 ☐ Yes 2 🔣 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 K Other (Specify) HOSPICE 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural 2 Accident 3 Suicide 5 Dending work?
1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 MORGAN CRNP TRACIE L. 31. Date filed (Month, Day, Year)

Registrar

NOV O

12-08069
----------

Anthony Louis Oliphant, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 35651

Physic		1- For State Certificate of Death	Re	g. No.
		Decedent's Name (First, Middle,Last)	Date of Death     Month	
ical Exam	iner		Month October 24	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 16707 Governor's Bridge Road Bowie	on of Death	4c. County of Death Prince George's
Funeral				(MM/DD/YYYY) 9. Birthplace (State or
Director		239-63-0297 1 X M 2 F 23 Yrs. Months Days Ho	ours Min. March	24,1989 Foreign Country) NC
any		10a. State 10b. County 10c. City, Town or Location		10d, Inside City Limi
<b>E</b>	_	MD Prince George's Bowie		1 Yes 2 X
aryland 8a-f show at once.	cto	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
the M. A or 2 tiffed	Director	16707 Governor's Bridge Road Apt 101 20716		USA
DAILUITIOFF, MID X IX 15-1030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 7: is marked other than "aatural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C 14. Never Married 2 Married Armed Forces? 15. Never Married 2 Married Armed Forces?		14. Race - American Indian, Black, White, etc.
er dez	Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No spec	nih.	Specify: Black
rs aft ural"	by	15. Decedent's Education (Specity only highest grade completed)  16a. Decedent's Usual Occupation (Gi		16b. Kind of Business/Industry
2 hou	ted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO No		Federal Government
und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Jdu	12 Assistant Clerk		Service Agency
ed wii ygier ygier other he M	Completed	17. Father's Name (First, Middle, Last) 18.Mot	her's Name (First, Middle, M	aiden Surname)
be file ntal H rked	Be	Anthony Louis Oliphant, Sr. Ka	aren Carr	
d Me	ျ	19a. Informant's Name/Relationship (Type, Print ) Father 19b. Mailing Address (Street and N		
alth and m 27 is		Anthony L. Oliphant, Sr.   16707 Govenor's		
F Heal		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
permit. Pages 1 ar Department of Hee Important: If ite nijury or other tr		4 Donation 5 Other Specify: Lofton AME Church Cen	n   10-30-12	Wrens, GA
mit. partm ports ury o		21. Signature of Funeral Septine Licensee 22. Name and Address of Fac		tan Funeral Service
E E B B	1	Men Dand Se	-	reet Alexandria, VA
hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	s cardiac or respiratory arres	st, shock, or heart Approximate Interv Between Onset an
Medical Examiner		Immediate Cause (Final disease a Dilated Cardiomyopathy		Death
Adminici		or condition resulting in death)  Due to (or as a consequence of):		
	L	Sequentially list conditions, b		
	0			
	2.	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
+	camin		***	
cuted nd transit	I Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
e executed cian and rial - transit	ल	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	12 sm	
ate be executed physician and he burial - transit	Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE:  23c. If yes, outcome of pregnancy	12 sm	23d. Date of delivery
ertificate be executed ding physician and e as the burial - transit	Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Z UNPENDED AMENDED 23a,27,per me,g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  AMENDED 23a,27,per me,g934 12-19-1	12 sm	23d. Date of delivery  Month Day Year
eath certificate be executed attending physician and for use as the burial - transit	Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  Z UNPENDED  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ector of the control of the c		
the death certificate be executed by the attending physician and ched for use as the burial - transit	Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Z UNPENDED AMENDED 23a,27, per me,g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  C Due to (or as a consequence of):  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	opic pregnancy	
s that the death certificate be executed greed by the attending physician and edeached for use as the burial - transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  Z UNPENDED  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ector of the control of the c	opic pregnancy	Month Day Year
quires that the death certificate be executed en signed by the attending physician and uld be detached for use as the burial - transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Z UNPENDED AMENDED 23a,27, per me,g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  C Due to (or as a consequence of):  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	opic pregnancy	Month Day Year  acco use contribute to the cause of death?  2  No 3 Probably 4  Unknown
aw requires that the death certificate be executed ras been signed by the attending physician and 2 should be detached for use as the burial - transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Z UNPENDED AMENDED 23a,27, per me,g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  C Due to (or as a consequence of):  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ppic pregnancy  23e. Did tob  1 Yes  24a. Was an autops	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown  24b. Were autopsy findings available prior to completion of cause of
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Z UNPENDED AMENDED 23a,27, per me,g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  C Due to (or as a consequence of):  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	opic pregnancy  Part I. 23e. Did tob  1 Yes  24a. Was ar	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
ing: The law requires that the death certificate be executed certificate has been signed by the attending physician and extor, page 2 should be detached for use as the burial - transit	Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  MENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  C.  Due to (or as a consequence of):  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  Part II. Other significant conditions  contributing to death but not resulting in the underlying cause given in	23e. Did tob  1	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
bysician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial - transit	Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):    X UNPENDED	opic pregnancy  23e. Did tob 1	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene
ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.    X UNPENDED	ath (Check only one)  23e. Did tot 1  Yes 24a. Was ar autops perform 1  Yes 2  ath (Check only one)  Nursing Home 5  F	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
tending Physician: The law requires that the death certificate be executed teath.  tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or	ath (Check only one)  23e. Did tot 1  Yes 24a. Was ar autops perform 1  Yes 2  ath (Check only one)  Nursing Home 5  F	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene
or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and I in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d  WUNPENDED  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  contributing to death but not resulting in the underlying cause given in the examiner?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  contributing to death but not resulting in the underlying cause given in the examiner?  1 Yes 2 No Other  25. Was case referred to medical examiner?  1 Yes 2 No Other  26. Place of Death 1 No Other  27. Manner of Death 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, street, factory, office building, 28e. Place of Injury - At home, farm, str	popic pregnancy  23e. Did tob  1	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabent of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene  w injury occurred
pital or Attending Physician: The law requires that the death certificate be executed ours after death.  Briector: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d  WUNPENDED  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  Contributing to death but not resulting in the underlying cause given in the underlying cause given in the past 12 months.  25. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown  Contributing to death but not resulting in the underlying cause given in	23e. Did tob  1	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabent of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene  w injury occurred
Expiral Division of Vital Recolus, F.O. BOX 60/00, 124 hours after death. 2 for a state death. 2 for a state death. 2 for a state death. 3 for a state death. 4 for this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d  WUNPENDED  AMENDED 23a, 27, per me, g934 12-19-1  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in the examiner?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in the underlying ca	ath (Check only one)  Nursing Home 5 Fork?  28d. Describe how or Town, Sta	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabe prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene w injury occurred  reet and Number or Rural Route Number, Citete)  (s) and manner as stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fuoran Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.    X UNPENDED	23e. Did tob  1 Yes  24a. Was an autops perform  1 Yes  24h (Check only one)  Nursing Home 5 R  Ork?  28d. Describe how  or Town, State of Cocurred at the time, date and cocurred at the	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availat prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene we injury occurred  reet and Number or Rural Route Number, Citete)  (s) and manner as stated.  Individual place, and due to the cause(s)
VISION OF VIGAL RECORDS, F.C. BOX 000 or Attending Physician: The law requires that the death certific fare death. Therefore, After this certificate has been signed by the attending I in by the funeral director, page 2 should be detached for use as the order of the control of	To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of reaccents and the consequence of reaccents and example and	23e. Did tob  1 Yes  24a. Was an autops perform  1 Yes  24h (Check only one)  Nursing Home 5 R  Ork?  28d. Describe how  or Town, State of Cocurred at the time, date and cocurred at the	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabe prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene w injury occurred  reet and Number or Rural Route Number, Cite  (s) and manner as stated. Indicate the cause(s)  29d. Date signed (Month, Day, Year)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.    X UNPENDED	23e. Did tob  1 Yes  24a. Was an autops perform  1 Yes  24h (Check only one)  Nursing Home 5 R  Ork?  28d. Describe how  or Town, State of Cocurred at the time, date and cocurred at the	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availat prior to completion of cause of death?  No 1 Yes 2 No  esidence 6 Other: Scene we injury occurred  reet and Number or Rural Route Number, Citete)  (s) and manner as stated.  Individual place, and due to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Fuorral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  MENDED 23a, 27, per me, g934 12-19-1  IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in contributing to death but not resulting in the underlying cause given in the past 12. Manner of Death    Manner of Death   Pending   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at West of Month, Day, Year)   28c. Place of Injury (Month, Day, Year)   28c. Place of Injury - At home, farm, street, factory, office building, (Specify)  29a. Certifier   Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated.  29b. Signature and title of certifier  O.C.M.E.	ath (Check only one)  Nursing Home 5 F  No  28d. Describe ho  or Town, Sta	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabe prior to completion of cause of death?  1 Yes 2 No  esidence 6 Other: Scene w injury occurred  reet and Number or Rural Route Number, Cite  (s) and manner as stated. Indicate place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  October 25, 2012
To the Hospital or Attaching Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Ruoral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  X UNPENDED  IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in 1 Yes 2 No 1 No 1 Noture 1 Not	ath (Check only one)  Nursing Home 5 F  No  28d. Describe ho  or Town, Sta	Month Day Year  acco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings availabe prior to completion of cause of death?  1 Yes 2 No  esidence 6 Other: Scene w injury occurred  reet and Number or Rural Route Number, Cite  (s) and manner as stated. Indicate place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  October 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER MARK OSTROW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HIL HARFORD HOOPER HOUSE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Min. Hours Director 220-72-1901 1 🕅 M 2 🗆 F 01/29/1966 46 MD Yrs Usual Residence of Deceden ir then "naturel", or items 23e or 28e-f show the Medical Examiner πust be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director HARFORD FOREST HILL 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23e Funeral 21050 USA 2007 KLEIN PLAZA DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. δ 1)(L) Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Importent: If Item 27 is marked other then 'eny injury or other treumatic event, I'm Magnes, once College (1-4 or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. REAL ESTATE MORTGAGE BROKER Be filed Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEVERLY LASOV Page 1 and 2 should be OSTROW MORTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY LASOV/MOTHER 5715 PARK HEIGHTS AVENUE, #107. BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEM 11/09/2012 4 Donation 5 Other (Specify) OWINGS MILLS. 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Sig. f Funeral Service Lic has 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events Due to (or as a consequence of) siclan and burial-transit Due to (or as a consequence of): resulting in death) Last physiclan a Physician/Medical Records, P.O. Box 68760 use as 1 attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy To the Hospital or Attending Physicien: The law requires that the death on within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes Natural 5 Pending 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 30. Name and addre 21093 State Registrar DHMH 17 Rev 06-2011

12-08275 Ralph Pulley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 1, 2012 **Medical Examiner** Ralph Vernon Pulley 1944 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 507 Fuselage Avenue Middle River **Baltimore County** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 220-74-8421 Months Days Hours 04/24/1958 1 X M 2 F Country) MD 54 Yrs. Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 Fuselage Ave. 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married 2 Married 2 X No Yes after 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced Black ģ Pages 1 and 2 should be filed within 72 hours; ment of Health and Mental Hygiene. fant: If item 27 is marked other than "naturs or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wardhanes timore, MD 21215-0036 Landscaping 10th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) John B. Pulley Gloria S. Wiggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Pulley (Brother) 507 Fuselage Ave. Balto., MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) tunt: 11/9/12 Baltimore, MD On-Site Crematory Donation 5 Other Specify ure of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave. Funeral HomePA Balto., 3a. Part Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval fail re. List only one cause on each line Between Onset and /Medical Death a Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death). Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g934 12-4-12 sm UNPENDED the attending physician ed for use as the burial -Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 V Unknown peen 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has funeral director, page 2 sl performed? Yes 2 ✔ No death? 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital B Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural subject ingested Methadone 1 Yes 2 X No Pending fd 11-1-12 fd1930 hrs To the Funeral Director: completely filled in by the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 507 Fuselage Ave. Middle River, MD. 28e. Place of Injury - At home, farm, street, actory, office building, etc. 3 Suicide Could not be Fd:Residence (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. November 2, 2012 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 Physician/ Powell Norma November 10:09 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Director 212-62-6380 1 M 2 K F 60 07-09-52 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Known as Norma Powel 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 2305 Poplar Grove Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. African should be filed within 72 hours after c and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married 2 Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates American 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) London Fog Company 12th Grade NA Seamstress permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rhuebottom Rhuebottom Dorothy Leon. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Poplar Grove Street Baltimore, Maryland 21216 Ernest Powell-Husband atient 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-12-12 Randallstown, MD King Memorial Pk. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition **WOUT**U Medical resulting in death) Due o (or as a consequence of): Examiner limb ischewio Sequentially list conditions, if any leading to in mediat-cause. Enter Underlying Cause (Disease or injury that initiated events Examine tue to for es a consecuence off sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Box 68760 signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by thrombocytopenia lupus, severe 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2. autopsy Yes 2 1 Yes 2 No 25. Was case referred in medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA |요 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) RES-000 MD November 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YUMULMO Sinai Haspital of Baltimore 31. Date filed (Month, Day, Year) State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35655 State Certificate of Death Registrar 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ November 02, 2012 07:00 P M Maniben M. Pate1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Social Security Number 7, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 218-27-2571 Director 1 M 2 X F India 86 August 1, 1926 Yrs Usual Residence of Decedent show 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Wheaton 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 India 2007 Glenallan Avenue 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married Yes ò Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify: Asian Indian 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Le, Mary.

Lefrmit. Page 1 and 2 should be 1
Department of Health and 1.
Important: If item 2.7
any injury or ...
once. ဂ္ Patel Mathurbhai Patel Gangaben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Glenallan Avenue, Wheaton, Maryland 20902 Hasumati A. Patel/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date West Arunde Lother place) Crematory 1  $\square$  Burial 2 XCremation 3  $\square$  Removal from State November 2012 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Eddones M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic Shock Secondary to Pneumonia Medical Due to (or as a consequence of) **Examiner** Renal Insufficiency Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Cardiomyopathy the burial-trar that initiated events The law requires that the death certificate be exect Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760  $\ll$ physician Physician/Medical as nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 X No Month Pregnant at time of death Day Year the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 X Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After the Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

Anisha Kumar, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

D0073240

November 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35656 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Orville L. L. Pollard Medical 1:31 a M November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) **Director** 579-46-7398 1 🖾 M 2 🗆 F 75 Yrs. Usual Residence of Deceden May 15. D.C. pernit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10c. City, Town or Location 10b. County **Funeral Director** 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 20772 13906 Gilbert Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Marie Hargrove Orville H. Pollard, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13906 Gilbert Street, Upper Marlboro, MD 20772 Klevin W. Pollard. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery November 10, 2012 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Suitland, MD 4 Donation 5 Other (Specify) 21. Sign ature of Fundry S 22. Name and Address of Facility Codar Hill Funeral Hone Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 odisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part . Enter th Approximate shock, or hear Interval Between Onset and Death Immediate Cause (Final Physician/ sersis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the Attunetal director, page 2 should be deteched for use as the burliel-transit After this certificete hes been signed by the ettending physician end funeral director, page 2 should be deteched for use es the burlel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medica 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SAN KOMMO 069 73 11/4/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 0 7 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 2012 Milton Paisner 7:45 p M November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Min. Hours May 20, Year) 1 🛛 M 2 🗆 F Massachusetts **Director** 97 012-09-0166 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 28a-f 1 XYes 2 No MD Rockville Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral USA 6111 Montrose Road 20852 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) Electronics 5+ Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abraham Paisner Anna Magid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Paisner/son 30914 Del Rey Road Temecula, CA 92591 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 11/06/12 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Heckrotte. P.A. Clarksville. MD Beverly L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Years Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 Yes 2 No **Division of Vital** or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: PAISNE 1 Tes 2 No ုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 1 Natural (Month, Day, Year) 5 Pending work' 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rel Rocherille MD 20852 LODUIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Day Owen Ray Peyton, Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE AGN SAINT HOSPITAI 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/26/1943 Social Security Number Funeral Days Hours Min. Director 1 M 2 □ F 220-60-9138 68 Yrs Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f shove may injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21230 1820 Spence Street, Apt. 202 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 😾 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give Specify 3 Widowed 4 Divorced Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Service Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Ebenhack Owen Ray Peyton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3554 Coco Lake Drive, Coconut Creek, FL 33073 Teresina B. Peyton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/7/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Dorok & Warshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death POXIL Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-trensit completely filled in by the funerel director, page 2 should be detached for use es the burial-trensit rdios Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? تَ To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ivision 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) תח ALMES IMIAC 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per doc 2933 11-7-12 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Year/2 Day 19 Physician/ Phalps John C , 0537 AM Medical 4a. Unitversitystystyfn Maryland Medical Centerb. City, Town, or Location of Death **Examiner** 4c. County of Death 5. Greens 54 Baltimore City Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 215-40-5193 1 🖾 M 2 🗆 F MD 08/17/1944 Usual Residence of Decedent show 10c. City, Town or Location within 72 hours after death with the Maryland aţ 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified MD Harford Forest Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1907 Deer Spring Ct. 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black White etc. 1 Never Married 2 X Married Completed by 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compensation Manager Northrup Grumman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Charles C. Phelps Grace E. Hommerbocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Phelps 1907 Deer Spring Ct., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 10/23/2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Schimunek Funeral Rome 610 W. MacPhail Rd., Bel Air, MD 21014 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Phenmonia Medical Due to (or as a consequence of): Examiner months ung transplant Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director, After this certificate has the thing of the th autopsy perform Yes 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1063778587 10/19/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland chen Michael Greene MP 22 5. 54 31. Date filed (Month, Day, Year) Registrar's Signature NOV 0 Registrar

12-08359 Melissa A. Pittman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

leiissa A. Pittm			Certificate of Death	Reg. No. 20	2 35660
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)  Melissa A. Pittman		2. Date of Death Month Day Year November 4, 2012	3. Time of Death 2238 hrs
neuicai Laiiii		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	th 4c. County of Dea	
		328 Kearney Drive	Owings Mills  rs last birthday) If Under 1 Year If Under 24H	Baltimore Co	
Funeral Director		250-53-5582 1 M 2 XF	rs. last birthday) If Under 1 Year If Under 24H Months Days Hours M  47	Fore	ign South ountryCarolina
any	ŀ	Usual Residence of Decedent         10a. State         10b. County         10c. (	City, Town or Location		10d. Inside City Limits
Maryland 28a-f show	5	MD Baltimore	Owings Mills		1 Yes 2XX No
e Mary or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	
215-0036 be filed within 72 hours after death with the Maryland mall Hygeine. rked other than "natural", or items 23s or 28s-f sho ent, the Medical Examiner must he notified at once.		328 Kearney Dr.  11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was Decedent of Hispanic Origin? (		erican Indian, Black,
death v	Funeral	1\bigce_XNever Married 2 Married Armed Forces? 1 Yes X\bigce_XN N			
rs after ural",	à	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed	1 Yes XX No specify:  d) 16a, Decedent's Usual Occupation (Give kind of		White
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use n		
21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medical	dw	4	Registerd Nurse	Healt ne (First, Middle, Maiden Surname)	h Care
21215-00; ould be filed with 1 Mental Hygiene 5 marked other to ic event, the Me	Be Co	17. Father's Name (First, Middle, Last) William Oscar Pittman		by Branham	
212 ould be d Ment s mark		19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number of		
ore, MD ses I and 2 shot of Health and if item 27 is there traumatic		Nicki Nicholson/Partner	328 Kearney Dr. (	Owings Mills, MI	
Baltimore, MD 2121; permit. Pages I and 2 should be fil Department of Health and Mernal I Important: If item 27 is marked injury or other traumatic event,		1 Burial XX Cremation 3 Removal from State	crematory or other place)	1/9/12	
Baltimo permit. Page: Department of Important: 1	H	4 Donation 5 Other Specify: 21. Signature of Fuy ral Se also Licensee	Crematory 1.22. Name and Address of FacilityEC	1/8/12   <sub>Sykesvi</sub> khardt Funeral C	lle, MD hapel, P.A.
	a g	23a. Part I. Enter the disease, or complications that caused the do	11605 Reistersto	own Rd. Owings Mi	11s, MD2111 Approximate Interval
Physician	ş 2	failure. List only one cause on each line.		to respiratory arrest, shock, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Due to (or as a consequent	e Cardiovascular Disease		
	<u>_</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequen	ice of):		
	Examiner	(Disease or injury that initiated			
uted Id ransit	Exa	d.	·		
60, tte be executed hysician and e burial - transit	Medical	□ AMENDED 23a,pt	.II,27,per me,g934 12-6		
8760, ificate be up physicist the buri	Me.	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of	pregnancy  2 Fetal death 3 Ectopic preg	23d. Date of deliver	ery Day Year
Box 6876 e death certificate the attending phy ed for use as the	Physician/	past 12 months?			
D. BC the der by the a	Phy	Part II. Other significant conditions contributing to death but i	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raster death.  **In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by	Diabetes mellitus; morbid ob	esity;fentanyl toxicity	1 Yes 2 No 3 Pr	obably 4 🗸 Unknown
ords, I w requires as been sig	Completed by				autopsy findings available completion of cause of
tal Recordant The la certificate ha	Com		1 Yes 2 No 1 Y		
Vital ysician: his certif director.	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death (Chec 2 ER/Outpatient 3 DOA Other Nur	ck only one) sing Home 5 Residence 6 🗸 Oth	ier: Scene
n of V ding Phy 1. After th funeral o	n: To	1 ✓ Yes 2 No 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
ision Attendi or death. rector: A	atio	Natural 5 Pending  Accident Investigation	1 Yes 2 No	28f. Location (Street and Number or F	Pural Pouto Number City
Divis  spital or A  hours after ineral Dire y filled in b	Certification:	3 Suicide 6 Could not be determined (Specify)	At home, farm, street, factory, office building, etc.	or Town, State)	Aurai Noute Number, Oity
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowne)  Medical Examiner. On the basis of examinating	wledge, death occurred at the time, date and place, a ion and/or investigation, in my opinion, death occurre	ind due to the cause(s) and manner as st d at the time, date and place, and due to	ated the cause(s)
To with To com	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (A	
		Alle Branch Mis	O.C.M.E.	November 5, 2	012
		30. Name and address of person who completed cause of death Melissa Brassell, MD Assistant Medical Exa		nore, MD 21223	
s	tate	31. Date filed (Month, Day, Year) 32/Registrar's Signature 32/Registrar's Signature 33/Registrar's Signature 33/Registrar			
Regis		MOV 0 7 2012 Cheese	a. Darke		

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/  $P^{M}$ Nov.2, 201 3:43 Rosalie Powell Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** 1002 Ashland Court Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year, 15 74 Director 213**-**32-4758 1938 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1002 Ashland Ct. 21202 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates SpecifyBlack 'natural", Completed 3 Widowed 4 Divorced Х the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12thretired Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eddie Dixon Noralee Brogden 19a. Informant's Name/Relationship (Type, Print) (daughtep) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2821 Pelham Ave. Balto, Md. Janynee Bailey-Covington 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Nov. 10, 2012 Balto, Md. Trinity 21. Signature of Funeral Service Licens Calvin B. Scruggs Funeral Home 1412 E Preston St. Balto,Md. 21213 23a. Part 1. Enter the disease, or complications that saveed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Approximate Interval Between Onset and Death Immediate Cause (Final Pnysiciana Benign essentia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Typerch Se quentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury -tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 40

9 Unknown Month Day 5 Other (specify) Pregnant at time of death the a 🗌 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate has ral director, page 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 2 **1**0 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completed filled in by the fu ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

Erdnen Avenue, Baltimore, MD 3120 31. Date filed (Month, Day, Year) 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Isles

NOV 0

Registrar's Signature

6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day PERELMAN ARRA 02 2 0/2 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, N/A LEVINDALE HEBREW HOME BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/05/1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, UKRAINE Months 1 □ M 2 □ 216-37-6785 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ▼ No MD BALTIMORF BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 16 OLD COURT ROAD. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL PHYSICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **TSILA** TVERSKY PERELMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 TRAVERTINE DRIVE, #402, BALTIMORE, MD 21209 SIMON DUKSTANSKY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM.: 11/04/2012 REISTERSTOWN, MD 21. Sign vure o Funeral Şervic Vice see 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final GND STAGE DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ONGESTIVE HEART 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No

**Physician** /Medicai Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

"natural", or iter dical Examiner

r than "

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: if Item 27 Is marked other thrang hijury or other traumatic event, the once.

Director

Funeral

þ

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

physician and sthe burial-trans attending properties for use as

Division or Vital Records, P.O. Box 68760

after death.

I Director: After to in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are To the Funeral Dir State

Medical

Examine Physician/Medical Completed Be 25. Was case referred to medical examiner? P 27. Manner of Death Certification:

> 29b. Signature and title of certifier PHYSICIAN

Hospital:

5 Pending investigation

6 Could not be determined

28a. Date of Injury

(Month, Day Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 120064533

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINS ALE MCBLEW CICALIATULE CIR 2434 W. BELVENERE AVE. BATTIMORE M) RABATUMDE AJANI MD

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

1 Yes 2 No

Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32 Registrar's Signature NOV 07

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Eugene Russell, Jr. 2012 4:300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1027 Cathedral St. Apt. Baltimore 15L N/A If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 215-58-1747 Director 1 X M 2 □ F 59 IN 01/17/1953 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1027 Cathedral St. Apt. 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. 1 ☐ Yes 2 🕅 No If Yes, Give <u>م</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Children's Guild Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald E. Russell, Sr. Emma A. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Russell (Wife) Cathedral St. Apt. 1027 15L Balto.MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State On-Site Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 11/6/12 21. Signature of Funer I Service Licensee <sup>22.</sup> Nosephess H<sup>Facili</sup>Brown Jr. 2140 N. Fulton Ave. Funeral Home PA Balto., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physiciani 01 disease or condition resulting in death) ena Medical Due to (or as a consequence of) €Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Uiscase o. injury Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cula 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie M) 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) MD 21093 2360 Norman

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		and Mental Hyg	jiene	OFCCI.
				ertificate of Death		Reg. No. 2012	35664
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Deat     Month	th Day Year	3. Time of Death
5	Medic	al	ROSELEN AUGUSTINE REID		OCTOBE		
	Examin	er	4a. Facility Name (if not institution, give street and number)  KENSINGTON NURSING HOME	4b. City, Town, or Location of	or Death	4c. County of Deat	
1/1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	KENSINGTON  If Under 1 Year If Under 2			MERY thplace (State or Foreign
	Director		577-02-0342 1 □ M 2 X F 77 Yrs.	Months Days Hours	Min. (Month, Day, JAN 16	Year) Co.	untry) MAICA
	MC .		Usual Residence of Decedent	<u> </u>			
	yland -f sh ed a	<u>c</u>	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits 1 ☐ Yes 2X No
	e Ma r 28a notif	Pire	DC WASHING	TON 10f. Zip Code		40 035	
	iith th 23a o st be	Funeral Director	2721 N STREET SE	20019		10g. Citizen of What Co	untry?
	ems (	nue		. Was Decedent of Hispanic Orig	gin? (Specify Yes or No-	USA 14. Race - Ame	rican Indian
9	or it		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo	If Yes, specify Cuban, Mexican,	, Puerto Rican, etc.)	Black, White	e, etc.
8	ırs aft ural", LExa	Completed by	3 ★ Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐XNo Specify:		Specify: B	LACK
2-(	2 hou <b>"nat</b> i	plei	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most	of working	16b. Kind of Business	Industry
12	thin 7	, mo	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	-		
d 2	ed wi Hygie other	Be (	12TH 17. Father's Name (First, Middle, Last)	TEACHER'S AID	) <u>L</u> er's Name <i>(First, Middle, N</i>	GOVERN Maiden Surname)	MENT
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. If frem Z is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	RODERICK BROWN	To mound	, ., ., .,	WIS	
ary	hould ind M s mai			ling Address (Street and Nuntber			Code)
Σ	nd 2 s salth n 27 i ertra		MURIEL BROWN/SISTER 382	64th AVENUETH	ĪĀĀTTSVILLE,	MARYLAND	20785
ore	e 1 ar of He if iter or oth		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposer, cometery, cremetery, cremeter	position (Name of ematory or other place)	Date	20c. Location - City or	Town, State
<u>Ē</u>	Pag ment tant: jury c		4 Donation 5 Other (Specify) WASHING	TON NATIONAL	11/6/2012		
Baltimore,	permit. Page 1 and Department of Hes Important: If item any injury or othe once.		21. Signature of Fun Service Licensee	22. Name and Address of Facility		INS FUNERA	
	40 = 60	Ш	200 Post of June 10 disease are profited in a that are used the death December 1	7474 LANDOVER			
			23a. Part 1/ Thier 1/Le disease, or complications that caused the death. Do not en shock, or hear failure. List only one cause on each line.  Immediate Cause (Final	iter the mode or dying, such as d	cardiac or respiratory arre	;st,	Approximate Interval Between Onset and Death
4	hysician/ Medical		disease or condition resulting in death)  a. IAFEFFECTS OF Due to (or as a consequence of):	CEREBRAVASCULA	R DISEASE		
	Examiner		HIV				
		iner	Sequentially list conditions, if any, leading to immediate but to (or as a consequence of):				
4	uted nd ransit	ami	cause. Enter Underlying Cause (Disease or linjury that initiated events  c.				
60°52	e exectian al	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
90	ate be executed bhysician and the burial-transit	dic	d				
687	ertifice ding p	/We	IF FEMALE: 23c. If yes, outcome of pregnancy			00 1 5 1 1	
Вох	eath certifica attending p I for use as t	cian	in the past 12 months?	Ectopic pregnancy     Other (specify)		23d. Date of de Month	Day Year
m ·	requires that the de been signed by the should be detached	Physician/Me	1   Yes 2   No 9   Unknown				
P.0.	tnat t ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
ds,	quires en sig ruld b	led l			1 🗆 Y	es 2	robably 4 🗌 Unknown
Sor	aw rec as be 2 sho	Completed	24a. Was a				
Re	rsician: The law scertificate has be director, page 2 s	med? death?	2 🗆 No				
ta .	cran: ertific ector,	Be	25. Was case referred to medical examiner?	T	th (Check only one)		
<u> </u>	Pnysi this c	2	1  Yes 2 No 1 Inpatient 2 ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time		rsing Home 5 Reside		ify)
n o	or Attending Phys after death. Director: After this in by the funeral di	Certificate:	1X Natural 5 ☐ Pending (Month, Day, Year) injury	of 28c. Injury at work?  M 1 □ Yes 2 □		ow injury occurred	
sio	Atten r deal ctor: by the	rtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s			reet and Number or Ru	ral Route Number,
Division of Vital Records,	salor A safter al Direct		building, etc. (Specify)		City or Towr	n, State)	
_ :	Io the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after december. The Ahours after december 24 hours after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve				
	the Finin 24	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge	, death occurred at the time, date	and place, and due to the	cause(s) and manner as	stated.
	o		29b. Signature and title of certifier	29c. License number	889	29d. Date signed (Mont)	i, Day, Year)
			30. Name and address of person who completed gauss of death (Item 23a) (Type	Print)	001	10/01	11-
	1			DO MCCOM.	55 Ave	KENSINGT	mus 20895-
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registra	ar	MUVU 12012 Beneval & Small	0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Rita A. Raab Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Good Samaritan Hospital 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Days Hours 213-20-5196 Director 1 □ M 2 🛣 F 88 Baltimore, MD May 19, 1924 27 is marked other than "natural", or iteme 23a or 28a-f shov traumatic event, the Medical Examiner must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2218 Lowells Glen Road, Unit B. 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANO
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Maryland 21215-0036 Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fill Health and Mental ည Ferdinand Franz Mary Beckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 f Health Frederick Raab (Son) 8333 Governor Ridgley Lane, Ellicott City, Maryland other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State November 09, Cardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Fhysician/ Medical Due to Examiner eurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use es the burlei-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death Year is certificate has been signed by the a director, page 2 should be detached is 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ The law requires Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has Hospitai or Attending Physician: 24 hours efter death. **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Practitioner: To the basis of my Propriet of the Cause of the Ca (Check only on 29b. Signatyr 29c. License number MARGELY completed cause of death (Item 23a) (Type, Print) 30, Name and address of person who State Registrar

State

Registrar

31. Date filed (Month, Day,

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ABINOWITZ : 06 PM 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER ROCKVILLE MONTGOMERY WASHINGTON , MARYLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 💢 F 79-12-6056 New York **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 【 No Specify: 3 ☒ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sadie Lefkowitz permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once, George Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2425 Lillian Drive, Silver Spring, Maryland 20902 Gail Blatt - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ohev Shalom Cemetery 11-4-2012 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Edward Sagel 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEXRT FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner PERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit YPERTENSION Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live as Section Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗷 No Hospital Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number famile det M.D. D0072714 2012

Registrar

V DHMH 17 Rev 7/2009

State

ROCKVILLE, MARYLAND 20852

6121 MONTROJE RD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES E. LETT 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM# I perphys, G933, IT/ 14/2012, WS are Legible.

State of Maryland / Department of Health and Mental Hygiene
AMEND TIEM# The Perphysical of Death

Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Rechtsteiner Terence Michael Rechtsteiner Physician/ Nov 2012 1:30 pм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 1812 Belle Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth May 3, 1954 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours Mary Tand Director 219-62-4068 58 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🕅 No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a USA 21222 1812 Belle Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items; any july or other traumatic event, the Medical Examiner musonce. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Computer Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Patricia Ann Dailey John Charles Rechtsteiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1627 Thetford Road Baltimore, MD Jessica Kalb Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Nov 5, 2012 Hilltop Service Corp Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Neis 122. Name and Address of Facility Duria-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Ligensee 7922 Wise Avenue Dundalk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CIRRHOSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician a Physician/Medical P.O. Box 68760 IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant signed by the atter in the past 12 months?
1 Yes 2 No Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, CORUNARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗷 No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of continer 29c. License number 29d. Date signed (Month, Day, Year) M. D D61777 11,2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TBIVSON MD 21204 TORNAM OSLEVE DRIVE 7505 JOSHUA SETH 32. Regis ar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) RABERTS **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Essex Riverview Nursing Home | Frank | Fran 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2 🔀 F Yrs. 1914 Massachusetts 98 Director 213-34-8198 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evariant must be notified at 1 ☐ Yes 2 X No Director MD Edgemere Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21219 3 Strebor Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 N Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Reads Drug Store 12 should be filed w h and Mental Hygier 7 Is marked other th Cook 11 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marv Kumala Charles Bloom ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any injury or other traun 2102 Oscar Beaver Dr. New Windsor, MD Carolyn Hanson (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 11/7/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee Michael Neiser 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, . Name and Address of Facility (ichal 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 5 ☐ Other (specify) □Yes 2□No P.0. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 No certificate. 1 ☐Yes 2 ☐ No 1 □ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Universing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ridenour, Richard Dennis 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti Franklin osedale more Square Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours (Month, Day, Year) 216-54-4894 Director 1 XM 2 □ F 62 Maryland July 27,1950 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director Essex MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 21221 924 Garden Drive Apt. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes, Gi Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: 3 Widowed 4 XDivorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Disabled Mental Hygier other 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Ann Tittle John W. Ridenour, Sr. とりつとと and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Barron Avenue Essex, Maryland Health a (Son) Jeremy Ridenour Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11/12/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Sig / tur + of Funera ense Charl Fisher Inc. 21222 0 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Due to (or as a consequence of): ute disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying ard, omyo Cause (Disease or injury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Pregnant at time of death Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 MER/Outpatient 3 I DOA ၉ 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After 1 injury 1 Natural 5 Pending Accident
Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) D005609Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:39 AM

1 Yes 2X No

Registrar DHMH 17 Rev 06-2011

State

Edana

Date filed (Month, Day,

Mann

32. Registrar's Signature

9000 Franklin Square Dowe Baltimore, MD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ chardsor Medical 4a. Facility Name (if not institution, give street and number University of Maryland W **Examiner** 4c. County of Death Maryland Medical Baltimore Cente Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 218-64-2341 57 Director Usual Residence of Decedent shov 10a. State 10c. City, Town or Location Director must be notified MD Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 226 S. Carey Street 21223 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? ō Completed by 1 Never Married 2 ☐ Married Black, White, etc. 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give "natural", Specify 3 Widowed 4 Divorced Year or Dates cartment of Health and Mental Hygiene. cortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sara Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Clarence Simms / Son 226 S. Carey Street, Baltimore, MD 21223 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) Chesapeake Crematory 11/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Der art Import any inj once. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Physician/ Endocarditi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 the as 1 yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? Yes 2 M No To the Hospital or Attending Physician: The Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 🛭 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural Pending work? 2 No Accident Suicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 $\square$ Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NPI 1043538069 11/2/2012 mon

ZO I

222M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 🗆 No

Countyland

**USA** 

Own Home

Beltsville, MD

Month

death?

Day

Year

Interval Between Onset and Death

Black

DHMH 17 Rev 06-2011

State Registrar Baltimore, MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35672 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV. Physician/ CLYDE L. ROBERTS, JR. 2012 18:55 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 219-30-8530 8/17/1935 1 X M 2 □ F 77 **Director** MD Usual Residence of Dece or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD 1 Yes 2 No BEL AIR 10e. Street and Number 10f, Zip Code 9 10g. Citizen of What Country? ms 23a oi must be Funeral 8 PEABODY CT 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify WHITE "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) AUTO PAINTER AUTOMOTIVE other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLYDE L. ROBERTS, SR. ELAINE SELUAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE ROBERTS-WIFE of Health BELAIR, MD 21014 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any injury or BALTIMORE, MD 1/10/12 | DALLIFIONE, FID SCHIMUNEK FUNERAL HOME BEL AIR 21. Signature of Funeral Service Lice 22. Name and Address of Facility 610 W. MACPHAIL RD BEL AIR, MD 21014 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tying, such as cardiac or respiratory arrest,
Approximate Interval Between Onset and Death,
Approximate Interval Between Onset Interval B shock, or heart failure Immediate Cause (Find Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** WING SWEEL GOD STORE LUNG QUESTIG Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant 9 Unknown Day Pregnant at time of death 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 🗌 Yes 2 🎒 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred To the Hospital or Attending Matural 5 Pending injury 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

5

80

0

50

9

7

800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1254R /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 116-36-6280 1- M 2 □ F Director Virginia Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show at 1 ☐ Yes 2X No Director Baltimore iral", or items 23a or 28a-f s Examiner must be notified Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 529 South 48th Street 21224 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plant Management Manufacture 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Reed Pearl Mullins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra MaryAnn Reed Wife 529 South 48th Street, Dundalk, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 X Burial 2 Cremation 3 Removal from State 8, 2012 Dundalk, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ature of un ral Service License <sup>22</sup> Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Obset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 18E The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760, attending physiciar Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 □ No P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of gleath? Division of Vital Records, ģ page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has perform 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2X ER/Outpatient 3 🗆 DOA 6 Other (Specify) ပ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyfier of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 X Natural Injury or Attending 1 🗌 Yes 2 No death. 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide after City or Town, State) within 24 hours a To the Funeral C 1 😾 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed npleted cause of death (Item 23a) (Type, Brin 6W16-10 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month,-Day, Year) State Registrar

DHMH 17 Rev 1/2001

	Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.  amend 19a, per fn, g933 11-13-12 sm  State of Maryland / Department of Health and Mental Hygiene  amend #11&19a Per FH G933 11/15/2012  Certificate of Death  Reg. No. 2012 35674										
				ilalya Per l	Certificat	e of L	Death		Reg. No. 2	112	35674
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Arthur Lewis Sato	rhell Tr				2. Date of De Month	Day	Year	3. Time of Death
many	Medic Examin		4a. Facility Name (if not institution, give street a			Town, or	Location of Death	<u> </u>		012 by of Death	16:28 p ™
	27.611111		Gilchrist				more				N/A
	Funeral Director		5. Social Security Number  217-62-1438  6. Sex  1 □XM 2	7. Age (In yrs. las:	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 09 / 03	y, Year)	g. Birt Coເ	hplace (State or Foreign Intry) MD
	iryland a-f show led at	Director	Usual Residence of Decedent  10a. State		Town or Location timore	l	<u> </u>	<u> </u>			10d. Inside City Limits 1 🗓 Yes 2 □ No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10e. Street and Number 1714 Poplar Grove			p Code	21216		10g. Citizen o	f What Co	untry?
	eath w	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. Was Dece	dent of Hi	ispanic Origin? (Spanic, Mexican, Puerto	ecify Yes or No-	14. Ra		rican Indian,
21215-0036	ırs after dı ıral", or il I Examine	Completed by I	1 Married 1 Married 1 M	ned Forces? ☑ Yes 2 ☐ No es, Give ar or Dates.			n, Mexican, Puerto Specify:	Hican, etc.)	Speci	ack, White <sup>fy:</sup> Bl	ack
15-0	72 hou rnatu ledica	nplet	15. Decedent's Education (Specify only highest grade com			rk done c	ation furing most of work	ing	16b. Kind of	Business/	Industry
212	within giene. er thar the N		Elementary/Secondary (0-12) Col	lege (1-4 or 5+)	life. DO NOT us	e reurea)	N/A		Disa	ble	
pu	e filed tal Hyged oth event,	To Be	17. Father's Name (First, Middle, Last)	hall Cm			18. Mother's Nam				
ıryla	d Men marke		Arthur Lewis Sato		19b. Mailing Addres	n /Street	Joanna				
<b>M</b> a	d 2 shoalth an alth an 27 is		19a. Informant's Name/Relationship (Type, Prin Debra Beborah Dunlap (F	"Wife <del>'riend)</del>		,					MD 21216
			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Remov	al from State Cer	ace of Disposition (Na metery, crematory or	other plac	:e)	Date	20c. Location	•	
Iţi m	it. Pag intmen intent: injury		4 ☐ Donation 5 ☐ Other (Specify)	On-	Site Cre						
Ba	The Burial 2X Cremation 3 Removal from State On-Site Crematory 11/7/12 Baltimore, M. Donardon 5 Other (Specify)  21. Signature of Furieral Service Licens  22. Name and Address of Facility  23. Name and Address of Facility  24. Donardon 5 Other (Specify)  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  21. Signature of Furieral Service Licens  21. Signature of Furieral Service Licens  21. Signature of Furieral Service Licens  21. Name and Address of Facility  21. Signature of Furieral Service Licens  22. Name and Address of Facility  23. Name and Address of Facility  24. No. Full ton Ave. Balto., MD 2									ome PA D 21217	
	Pnysician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final	e on each line.	. Do not enter the mod	de of dyin	g, such as cardiac			3	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	metastad Due to (or as a conseque	ence of):	inov	<b>~</b>				
	p te	niner	cause Enter Underlying	Due to (or as a conseque	ence of):						
	executed ian and urial-transit	l Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
9	ate be physicia the bu	dica	d								
. Box 68760	The law réquires that the death certificate be atte has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medica	in the past 12 months?	res, outcome of pregnand Live Birth 2 Fetal Pregnant at time of de Unknown	death 3 Lectopic		cy			Date of del Month	ivery Day Year
s, P.O.	res that th signed by d be detad	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						obacco use co	pacco use contribute to the cause of death?		
cord	law require has been si ge 2 should	Completed			24a. Was an autopsy						
Participated in the participate of the participate									death?	3 2 □ No	
Vita	ysiciar s certii directo	To Be	examiner?  1  Yes 2  No  Hospita	l: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3 🗆 🛭	Oth	ace of Death (Checer: 4  Nursing H		dence 6 🗷 O	ther (Spec	ity) Hospica
Division of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director,	Certificate: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation			28c. Injur work	y at		how injury occu		1
Divisio	al or Atte s after des I Director d in by th		3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ry, office		28f. Location ( City or To		ber or Ru	ral Route Number,
<u>_</u>	To the Hospital or Attending Physician: "Thin's 2 hours after death as the Funeral Director. After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: On only only only only only only only onl	the basis of examination a	and/or investigation, in	my opinio	on, death occurred a	at the time, date	and place, and	due to the	cause(s) and manner stated.
51	vithin 2		29b. Signature and title of certifier		29	c. Licens	e number		29d. Date sign	ned (Montl	
ď	2 00/		MAN YCC	MD		100-	70635		11141	12	
	J. J.		30. Name and address of person who complet	<b>^</b>		4 8	vite 410:	5 Ba	(Americ	, Mp	21204
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signatu							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 35675 Terrence Seale State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month Day November 3, 2012 Medical Examiner 1439 hrs Terrence Seale 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1231 Linworth Avenue Apt. 3A Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Months Days Director Hours Min. 125-68-6460 29 10-13-83 NY 1<sup>X</sup> M 2 F Country) Usual Residence of Decedent 10b. County ij 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD NA Baltimore or 28a-f show , or items 23a or 28a-f shorr must he notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1231 Linworth Avenue Apt.#3A 21239 USA Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Forces? 1 Never Married 2 X Married 2 X No Yes American Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural?, of
injury or other traumatic event, the Medical Examiner I 3 Widowed 4 Divorced f Yes, Give Year 1 Yes 2 X No specify: δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA Student Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nigel Seale Deborah 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Marie Ann Seale-Wife 1231 Linworth Avenue Baltimore, Maryland 21239 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 Cremation 3 Removal from State Greenwood Cem. 11-13-12 Brooklyn, NY 4 Donation 5 Other Specify. 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last is been signed by the attending physician and should be detached for use as the burial - transi Physician/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' director, page 2 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other Scene After this 2 No မှ 1 Yes 28a. Date of Injury (Month, Day Year) Nov 3, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural 1415 hrs 1 Yes 2 V No death. 5 Pending To the Funeral Director: completely filled in by the 2 \_\_\_ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1231 Linworth Avenue Apt. 3A, Baltimore, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier (Cherk only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 4, 2012 O.C.M.E. ame and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Projetrar's Signature State

Registrar

OGME

12-08250 William Simmons

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 3567 State of Maryland / Department of Health and Mental Hygiene

	- 1	1- For State Certificate of De-Registrar		Reg. No.
Physicia Medical Exami	ın/	1. Decement's Name (First, Middle, Last) William Simmons	2. Date of Month Octol	of Death Day Year Der 31, 2012  3. Time of Death 2058 hrs
		4a. Facility Name (if not institution, give street and number)  4b. Cit	r, Town, or Location of Death	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	nder 1 Year If Under 24Hrs. 8. Date onths Days Hours Min.	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
	ŀ	56 - 71 - 2816   1 1 M 2 F   3d Yrs.   Usual Residence of Decedent		&: ((i)
nd show any ice,	7	10a. State 10b. County 10c, City, Town or Location	io.	10d. Inside City Limits 1 ✓ Yes 2 No
the Maryland a or 28a-f show tiffed at once.	Director	10e. Street and Number 10f. 5318 Carriage Court	Zip Code	10g. Citizen of What Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	h	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	edent of Hispanic Origin? (Specify Yes ecify Cuban, Mexican, Puerto Rican, et	s or No- tc.) 14. Race - American Indian, Black, White, etc.
2 hours after d "natural", or	â	3 Widowed 4 Divorced If Yes, Give Year 1 Yes  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Ust	2 No specify:  all Occupation (Give kind of work done working life, DO NOT use retired)	Specify: DIACK  16b. Kind of Business/Industry
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Floor	echnician	Self Employed
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica	Be	17. Flather's Name (First, Middle, Last) William A. Simmons		Thompson
MD 27 d 2 should th and Me a 27 is ms	٥	Benita Simmons/Mother 5318(	arriage Ct., B	altimore, MD 21229
Baltimore, MD permit, Pages I and 2 sho Department of Health and Important: Witem 27 is injury or other fraumati		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	ce)	20c. Location - City or Town, State 2 El Kridge, MD
Baltimo permit Page Department o Important: injury or oth	1		The same of the sa	tuneral Services
Physician Mucical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moderal failure. List only one cause on each line.	e of dying, such as cardiac or respirat	ory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (C.		
uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED		22d Data of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bun	Physician/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1		23d. Date of delivery  Month Day Year
P.O. Box 687 that the death certification and by the attending detached for use as t	Phys	Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I. 23e	Did tobacco use contribute to the cause of death?
S, P.O. uires that th n signed by d be detach	ed by		1[	Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, F tal or Attending Physician: The law requires as after death.  1 Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed			autopsy performed?  Yes 2 No  24b. Were autopsy findings available pnor to completion of cause of death?  Yes 2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one)	
ion of Vital   tending Physician: eath. for: After this certifi the funeral director,	리	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work? 28d. De	5 Residence 6 Other:
tion (trending death.	ation	1 Natural 5 Pending Oct 31, 2012 2016 hrs	1 Yes 2 ✓ No Subject	
Divisuital or A urs after ral Dire	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fact (Specify) Local Street	or T	ation (Street and Number or Rural Route Number, City Fown, State) arriage Court, Baltimore, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	the time, date and place, and due to the my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
<b>1</b>	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  November 1, 2012
3/1		30. Name and address of person who completed cause of death (Item 23a)		
, O,		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature		223
St Regist	ate trar	a manage of the state of the st	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 NOV MARY LOUISE STONE 5:05AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE KESWICK HOME BALTIMORE CITY CITY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 😾 F Months Days Hours (Month, Day, Year) Country 92 Director 216-01-8505 28 1919 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State Maryland 10b. County 10d Inside City Limits should be filed within 72 hours after death with the Maryland 10c, City, Town or Location Director Baltimore Baltimore County 1 Yes 2 XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA Funeral 3 Elmont Avenue items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian and Mental Hygiene.
is marked other than "natural", or iten 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ¥ ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 yrs. N/A Hairdresser Hutzler Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Ingram Eleanor Van Horn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Beverly A. Gibson (Daughter) 3138 Birch Brook Lane Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date Department of H
Important: If ite
any injury or otl X1XX Burial 2 Cremation 3 Removal from State Prospect Hill Cem. 11-7-2012 4 Donation 5 Other (Specify) Baltimore, Md. <sup>22. Name and Address of Facility</sup> Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 On Jure of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_ician/ ementla disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner NIS EASE VAS C Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Vear Day Pregnant at time of death the detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 40 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check onl one) funeral director, Be examiner? Hospital 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Adrsing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) injury 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifie 29c. License number

91

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

AC

31. Date filed (Month, Day, Year)

5901 nomb

who completed cause of death (Item 23a) (Type, Print)

,D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? \(\) Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death SHOVER Physician/ Aonth V 7.05AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Augsburg Lutheran Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-05-1094 1 M 2 X F Sept. 17 1912 Balt. Maryland Director 100 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Baltimore Baltimore Maryland 1 🗆 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 'n Og. Citizen of What Country? United States ral", or items 23a o Examiner must be Completed by Funeral with 21207 6811 Campfield Road of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black White, etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 white If Yes, Give 1 Yes 2 No Specify. Specify 3 XWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Bell Telephone Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ဂ္ Rose Rauh Morton Boston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Health a 9502 Holiday Manor Road Perry Hall, MD 21236 Mr. John J. Fuller/ son Department of Health Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 November Evans Funeral Chapel Bel Air ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6, 2012 Forest Hill, Maryland Signature i Fu ral Service Licens 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate DISA Prost and Death shock, or heart failure. List only one cause on each line THEROSCHEROTIL Immediate Cause (Final EREBROVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause (Disease or linjury Due to for as a consequence of, attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ TUPERTENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner' 1 Tyes 2 No Other ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mi 110000 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) P.D IWINGS MILL ASNEEM AKHAMI, mi 31. Date filed (Month, 32 State NOV 0 Registrar

12-08266 Wayne Smedley

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 3567	012 3567	
-----------	----------	--

	1-	For State	ato or many and	Cer	tificate of	Death			Re	g. No.	1 4	00012
Physician		. Decedent's Name (First, Middl	e,Last)						Date of Death     Month	Day Year		ime of Death
		Wayne Michael 9	Smedley						November	1, 2012		1623 hrs
	4	a. Facility Name (if not institution					n, or Loc	ation of Deat	h	4c. County of	Death	
		Upper Chesapeake H				Bel Air				Harford		
Funeral	5	. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Months		f Under 24Hr Hours Min	<del></del>	h(MM/DD/YYYY) F	oreign	
Director	12	214-82-9069	1X M 2 F	53	Yrs.	MOTUIS	Days	Hours   Will	07/27/	1959	Country	Maryland
	t	Isual Residence of Decedent										
ĥ.	- 1 '	0a. State 10b. County			Town or Locati							I. Inside City Limits
bud show	,   P	Maryland Harfor	d County	Fore	st Hill							Yes 2 XNo
the Maryland a or 28a-f show tiffed at once.	1	0e. Street and Number				10f. Zip Co	de		10	g. Citizen of What	Country?	
Diffied	5 2	2927 Grier Nurs	sery Road			2105	50			United St	tates	
with the Maryland as 23a or 28a-f sho be notified at once.	1	1. Marital Status	12. Was Decedent						Specify Yes or No- o Rican, etc.)	14. Race - A		Indian, Black,
r death with or items 23 must be no		Never Married 2 M	arried Armed Forces	√ No	"'	es, specify C	doan, we	SAICEIT, I GOT	o raiodii, oto.)			
s after ral", c	5	- 41	orced If Yes, Give Year or Dates:			Yes 2X				Specify: W		
ours xam		15. Decedent's Education (Spe			16a. Decedent			(Give kind of NOT use re		16b. Kind of Busin	ness/Indus	stry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exa		Elementary/Secondary (0-12)	College (1-4 or	5+)	Chauff	01176				Constell	latio	n Energy
withii iene.	ĒL	12	<u> </u>		Chaull	eur	140 1	Aothor's Nam	e (First, Middle, M			
Hyg Hyg		7. Father's Name (First, Middle							arie Enge			
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medica	֓֞֜֜֜֜֜֜֜֜֓֓֓֜֜֜֜֜֜֜֜֜֡֓֓֡֓֜֜֡֡֡֡֡֡֡֡֜֜֜֡֡֡֡֡֡	Charles Mann Sr 9a. Informant's Name/Relations			19h Mailing	Address (				ber, City or Town,	State Zip	Code)
MD 21215-003 2 should be filed within hand Mental Pygiene. 27 is marked other the imatic event, the Medi	- 1									ter, Mar		
e, MD 21215-0036  I and 2 should be filed within 72 hours at Health and Mental Hygiene. item 27 is marked other than "natural retaumatic event, the Medical Examing To Re Committed by	2	Ir. Ken Smedley Oa. Method of Disposition	(Brother)	20b. F	Place of Dispos	ition (Name			Date	20c. Location - C	ity or Tow	n, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1	I ☐ Burial 2 ☐ Cremation	n 3 Removal from St		erematory or other ans Fun		hanc	1 11	/06/2012	Forest 1	4:11	Maryland
timent tant:		Donation 5 Other S		E.V			-	1				- 1
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	- 1	Signature of Funeral Service	1/2 /		Eva	ns Fur	nera.	l Chap	el & Crema	ation Se	rvice	s-BelAir
	1	3a. Part I. Enter the disease, or	complications that caused	the death	Do not enter th	ewport	vina suc	t V⇔ Fo	cr respiratory arre	l Maryla	and Z	DDU pproximate Interval
Physician Medical	ľ	failure. List only one cause	on each line.				,g,	.,	,	,	В	etween Onset and Death
Examiner		mmediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic  Due to (or as a cons			ease					-	
Same of the same o	1		b.	equence o	1).							
1		Sequentially list conditions, f any, leading to immediate	Due to (or as a cons	equence o	f):							
	Į,	cause. Enter Underlying Cause Disease or injury that initiated	C.								_	
ted nisit	3	events resulting in death) Last	Due to (or as a cons	equence o	t):							
760, icate be executed physician and the burial - transit Madical Ex.	<u> </u>	UNPENDED	d									
760, cate be execut physician and he burial - tra									<del>-</del>	23d. Date of de	nlivon	
876 ificate g phy s the		F FEMALE: Bb. Was decedent pregnant in t	23c. If yes, outco	me of preg		tal death	3   E	Ectopic pregr	nancy	Month 23d. Date of di	Day	Year
cial	5	past 12 months?	4 Pregnant a	t time of de	oth —	her (Specify	_					
that the death certific the by the attending I detached for use as the by Bhysician	2	Yes 2 No 9 Un	known 9 Unknown									
d by t tacke		art II. Other significant condi	tions contributing to deal	h but not r	esulting in the u	inderlying ca	use give	n in Part I.		bacco use contrib	_	
Records, P.( The law requires tha ficate has been signed , page 2 should be det	2'  3								1 Yes	2 No 3	Probably	4 Unknown
rds requi									24a. Was a autop			y findings available letion of cause of
e law e has ge 2 s	1								perfor		ath?	2 No
ii The liftical or, pag		5. Was case referred to medica	1			26.	Place of I	Death (Chec				
Vital Records, P.C. ysician: The law requires that his certificate has been signed director, page 2 should be dete	ŏ	examiner?	Hospital: 1 Inpati	ent 2	ER/Outpatient	3 DOA	Oth	ner <sub>4</sub> Nurs	ing Home 5	Residence 6	Other:	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the start death.  The The record of the this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director.		1 ✓ Yes 2 No ?7. Manner of Death	28a, Date of Inj (Month, Day,		28b. Time of I		. Injury a			now injury occurred	1	
DD OD of the furth.		1 Natural 5 Pen	ding	rear)		1	Yes	2 No				
iSiG	3		estigation 28e. Place of I	njury - At h	ome, farm, stree	et, factory, of	ffice build	ling, etc.			or Rural F	Route Number, City
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune			ermined (Specify)						or Town, S	tate)		
y fill bou		9a. Certifier 1 Certifying F	hysician: To the best of n	ny knowled	ge, death occur	red at the tir	ne, date a	and place, ar	nd due to the caus	e(s) and manner a	s stated.	
To the Ho within 24 To the For complete	5	one) 2 Medicai Exa	aminer:On the basis of exa		ind/or investigat	tion, in my o	oinion, de	eath occurred	at the time, date	and place, and du	e to the ca	use(s)
E 3 E 8	Ĕ   :	29b. Signature and title of certifi				29c. L	icense ni	umber		29d. Date signed		Day, Year)
		Alla	Bullm	7			D.C.M.E	Ē.		November 2	, 2012	
	-	30. Name and address of person	n who completed cause of	death (Item	1 23a)							
		Melissa Brassell, MD				/. Baltimo	re Stre	et, Baltim	ore, MD 2122	23		
Stat	-	31. Date filed (Month, Day, Year,	32. Registr	ar's Signati	ure							
Registra	il.	MUV U 7 2012	Marian A	Mo	21 Kad							

**ORIGINAL** 

4

DHMH 17 Rev 1/2001

State

Registrar

NOV 0 7 2012 Buch A.

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio M.D., Ph. D.

31. Date filed (Month, Day, Year)

A. parker

Assistant Medical Examiner

OCME

32. Registrar's Signature

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

October 31, 2012

## Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 09:22 Haldi Ruth Silver Stepakof 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) 216-40-7884 1 □ M 2 □ XF 69 Yrs Washington, DC 3-24-1943 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Montgomery Potomac 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20854 9416 Holbrook Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Mish Joseph Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Joseph Stepakof - Husband 9416 Holbrook Lane, Potomac, Maryland 20854 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗌 Cremation 3 🗓 Removal from State cemetery, crematory or other place) King David Memorial Gardens 11-2-2012 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Brian Deibler 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death therosc resulting in death)

Ph sician Medical Examiner Physician/Medical Examiner

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

show

28a-f

ms 23a or must be r

'natural", or ite

items 2 death 1

Department of health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic conce.

notified at

Director

Funeral

ò

Completed

Be

၉

with the Maryland

use as

Completed by

Certificate: To Be

Medical

29b. Signature and title of cer

0/31/12 0922 Am

STEPAKOF

Division of Vital Records, P.O. Box 68760

attending physician and signed by the at d be detached for page 2 s after death.

Director: After this certificate I Hospital or Attending Physician: within 24 hours a

Sequentially list conditions, b							
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):						
Cause (Disease or injury that initiated events							
resulting in death) Last	Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23d. Date of delivery Month Day Year						
	tributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Nnknown				
		24a. Was an autopsy performed?					
25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)					
1 🗆 Yes 2 🖼 No	ospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H	lome 5 - Residence	6 ☐ Other (Specify)				
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1  Yes 2  No	ury occurred					
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	and Number or Rural Route Number, te)					
29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my knowledge, death occurred at the time, date and place, ir: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) at the time, date and place	and manner as stated. ce, and due to the cause(s) and manner stated.				

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Moth Leonard, MD - 3600 Old Georgetown Rd., Bethesda MD, 20814

066896

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 35682 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 6 6:30 A M Nov. В. Snyder Sara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 255 Oak Court Severna Park Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Hours (Month, Dav. Year) 395-32-6091 **Director** 1 □ M 2 🎇 F 17, 1935 Wisconsin 77 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 🗆 Yes 2 😾 No Wyckoff NJ Bergen 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 101 Sealed Stone Terrace 07481 United States ural", or items 2 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) New York Schools Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ္ Harriet Edgell Jackson Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Ann Mooradian (Daughter)</u> 255 Oak Court, Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Metro Crematory, Inc. 11/7/2012 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complete ins that caused shock, or heart failure. List only one cause on each line. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death BREAST CANCEL Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy filled in by the funeral director, page 2 Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Daughter' Be examiner? Other: 4 \( \sum \) Nursing Home \( 5 \sum \) Residence \( 6 \sum \) Other (Specify) Hospital: ျှ 1 Tyes Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injurv 5 Pending 1 Natural Accident Investigation 24 hours after death Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) 00064852 06/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6NCUCOCY J. GARG ANN APOLIT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ 7:50 PM Mark Nelson Stein Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAltimore Franklin Sq HOSPITAL ROSEDAIR UAR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Dec.3,1950 Days Hours Min. 61 215 48 7301 Director 1 🖾 M 2 🗆 F Yrs Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location than "netural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Essex Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 818 Creek Rd. 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than 'any Injury or other treumatic event, <u>the Meone</u>. other than Elementary/Secondary (0-12) College (1-4 or 5+) Aerospace Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Conroy Gordon W. Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Wehland (Personal Rep.) 818 Creek Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 11/6/2012 Baltimore, Maryland Bayview Crematory Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex 21. Signature of Funeral Service Licensee OW. Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner STAge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use es the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 D Yes 2 No ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 SNo Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 SInpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 00063289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square DrivE BAltimore, MD 2/237 MASOUD 32. Registrar's Signature State Registrar

RIN

charbotte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 4, 20 M2 Theresa Ann Saniro 8:50 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Prince Frederick Calvert Nursing Center Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. O & Conth. 28 Year) 1914 Pennsylvania 193-10-4857 98 Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c, City, Town or Location 10d. Inside City Limits Director 28a-f Calvert 1 X Yes 2 □ No Huntingtown Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral U.S.A. 20639 3721 Hollyberry Drive items and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🏋 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White Completed 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maria Cardamone Angelo Mazzei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Presa (Daughter) 3721 Hollyberry Dr., Huntingtown, MD 20639 20a. Method of Disposition

1 
Bural 2 
Cremation 3 
Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Belle Verron Cemetery 11/8/2012 Belle Vernon, PA 4 ☐ ponation 5 ☐ Other (Specify) ture of Funeral Service Licens RetropoliteanFadituneral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ entive cona Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury burial-transi that initiated events resulting in death) Last and attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No this certificate has ral director, page 2: 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending Accident Investigation eted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Prince Frederick, MD 20678 130 Hospital Rd. #300 Vijaya Guduri, M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

7

32. Registrar's Signature

12-08210 Stella Sanchez

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Stella S	Sanchez		S 1- For State Registrar	tate of Maryla		artment of rtificate of		d Mental		20 eg. No.	12 3568	
Medic	Physicia al Exami	an/	1. Decedent's Name (First, Midd Stella	R Sa		2. Date of Dear Month October 3	Day Year 0, 2012	3. Time of Death 1150 hrs				
			4a. Facility Name (if not instituti 7823 Marion Lane				Bethesda			4c. County of Montgome	ery	
	Funeral Director		5. Social Security Number 459–22–0489	6. Sex	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days		Min.		9. Birthplace (State or Foreign Country) Texas	
	daryland 28a-f show any 1 at once.	Director	Usual Residence of Decedent  10a. State 10b. County  MD Mon  10e. Street and Number	tgomery	1 1	Town or Locati thesda	on 10f. Zip Code		[1]	0g. Citizen of What	10d. Inside City Limits 1 X Yes 2 No Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	uneral Dire	7823 Marion La  11. Marital Status 1 Never Married 2 N	12. Was Dec		.S. 13. Wa	USA 14. Race - A White, 6	American Indian, Black, etc.				
	hours after de 'natural'', or Examiner mu	╙	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12		de completed)	16a. Deceden	Yes 2 No 's Usual Occupationst of working life.	on (Give kind		Specify: White  16b. Kind of Business/Industry		
5-0036	Hygiene.  d other than the Medical	Completed by	12 17. Father's Name (First, Middle	Hom	emaker		,	Own Home				
MD 21215-0036	2 should be f. h and Mental 27 is marked umatic event,	To Be	Victoriano Roo 19a. Informant's Name/Relation Felix R. Sancl	ship (Type, Print)			•	and Number	Cervera or Rural Route Num Bethesda,			
Baltimore, I	Pages 1 and ment of Heals tant: If item or other tra		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other S	Specify:	om State Sa	crem <del>at</del> ory of oth Metery metery	. –	olic 11	Date / 05 / 2012		tonio, TX	
	Depart Injury	7	21. Signature of Funeral Service 23a. Fart I. Enter the disease, o	(end)	aused the death	7.9	ame and Address	5517	Vine Stre	et Alexar	ral Service ndria, VA 2231 Approximate Interval	
	Vedical kaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. <sub>e a.</sub> Hypertensi		lerotic Cardi			olicated by Hyp		Between Onset and Death	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence o							
	be executed sician and urial - transit	dical E	UNPENDED	d AMENDED								
Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bun	₽Ì	IF FEMALE: 23b. Was decedent pregnant in from past 12 months?  1  Yes 2  No 9  Ur	the 1 Live b	nant at time of de	2 Fet	al death 3 [ ner (Specify)	Ectopic pre	egnancy	23d. Date of de Month	olivery Day Year	
P.O.	ires that the signed by the l be detache	Š	Part II. Other significant condi Dementia	tions contributing to	o death but not r	esulting in the u	nderlying cause gi	ven in Part I.			te to the cause of death?  Probably 4 Unknown	
Division of Vital Records,	ician: The law requirectificate has been sector, page 2 should	Completed							1 ✔ Yes	sy prio	re autopsy findings available or to completion of cause of other or to completion of cause of other or to complete or complete or to complete or to complete or to complete or complete or to complete or	
Vital	hysician: this certi Il director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	- Hospital:	Inpatient 2	ER/Outpatient	3 DOA			Residence 6	Other: Scene	
sion of	Attending Ph death. ctor: After t'	Certification:		estigation Oct 30,	1, Day,Year) : 2012	y at Work? es 2 ✔ No	Exposure to rain and cool environmental temperature					
Divis	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide dete	ild not be	Outside of	residence	t, factory, office bu		or Town, S 7823 Marion L	tate) ane, Bethesda, I		
	To the How within 24 h To the Fur completely	Medical	one) 2 Medical Ex	aminer:On the basis of and manner s	of examination a	-	on, in my opinion,	death occurr		and place, and due	to the cause(s)	
		2	29b. Signature and title of certification of the control of the certification of the certific	Hac	lai		29c. License O.C.N		_	October 31, 2	(Month, Day, Year) 2012	
3			30. Name and address of person Carol H. Allan, MD	Assistant Medic	cal Examine	r 900 W. E	saltimore Stre	et, Baltimo	ore, MD 21223			
	St Regist		31. Date filed (Month, Day, Year,	32. Re	egistrar's Signat	Te Made						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sharyn Lee Seifert 10:50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ROSEDALE SQUARE MEDICAL TIMORE If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Year) Dec . 27 . 1948 219 52 5194 Director 63 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1122 Stephen Drive 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? ğ 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Specify: Specify: White If Yes Give 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator 12 Snowball Stand permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, |Henry John Kroll Catherine Lorraine McCubbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy L.Trent (Daughter) 1122 Stephen Dr. Baltimore, Maryland 21220  $S \in \mathbb{R}$  Baltimore,  $\mathbb{R}$ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Oak Lawn Cemetery 11/8/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex 21. Signature of Funeral Service Licens Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician/ disease or condition resulting in death) MESENTERIC HEMORRHAGE OF UNKNOWN ORIGIN Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a use as the burial-Physician/Medical Division of Vital Records. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 120063289 2012 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore MD 21237 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

トロにソカ

Cr7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Charles William Sistek 1015 AM 11 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUERE HOSPITal Rosedale (TIMOL P 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min 217 24 7045 83 1 ੌ M 2 🗆 F Director Yrs Oct.24,1929 Maryland Usual Residence of Deceder iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Nottingham 1 🗆 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3-C Durban Ct. 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Ever III C.C. Armed Forces? 1 Xyes 2 No If Yes, Give Korean Year or Dates. War 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene, other than " Elementary/Secondary (0-12) College (1-4 or 5+) the Steel Mill Repairman injury or other treumatic event, Be lled Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Joseph Sistek Margaret Hughes permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other treumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3- C Durban Ct. Baltimore, Maryland 21236 Shirley Hisker(Personal Rep.) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ignatius Church Cem. 11/9/2012 4 ☐ Donation 5 ☐ Other (Specify) Hickory, Maryland <sup>22. Name and Address of Facility</sup>
Bruzdziński Funeral Home P.A.
1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service License C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Infarction Mycardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 25TIVE Sequentially list conditions, if any leading to in redictions cause. Enter Underlying Cause (Disease or injury Ever to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit bioprosthetic AOTTIC Value that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 d. IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: မ 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) emato RESODOO 11-5-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE Balto md 21237 Gopinohan, DGS DR 9000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 4, 2012 **Physician** NOVEMBER MARGARET SHANEY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Year)
Aug. 15,1942 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** 1 M 2 K F Maryland 70 217-38-7879 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location show 1 ☐ Yes 2 🔀 No or 28a-f sh notified a Director Edgemere MDBaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò must be 23a ( 21219 United States 2113 Lodge Forest Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ral", or iten Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 3No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2√ No Specify Specify: þ 3 Widowed 4 Divorced White "natura!" Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceutical Facilities<sub>.</sub> <u>Administrator</u> 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental H 27 Is marked oth traumatic even Frances M. Harp Samuel D. Hobbs, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2113 Lodge Forest Drive Edgemere, MD 21219 Gordon Clifton, Sr. (Companion) of Health other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If It any injury or conce. Baltimore, Maryland 11/8/2012 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee Justin A. Jones 7922 Wise Ave. Dundalk, Maryland 21222 P. 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List daily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical PANCREATIC CANCER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician ar I for use as the burial-Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Director: After this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) the Hospital within 24 hours a

To the Funeral C

completely filled Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Media and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature an MD RES-000 NOVEMBER 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 FORSTER CHHEAR 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SCHOENBAUER 1320 M 10 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOUSE FREDERICK CALVERT BURNETT CALVERT HOSPICE PRINCE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. 1 □ M 2 □ F 70 10/20/1942 D.C. 577-58-4606 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at 1 ☐Xes 2 ☐ No Director LaPlata MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20646 USA Funeral 7869 Bethany Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces:

1 Dyes 2 No Novy
If Yes, Give
Year or Dates: 1962-64 or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. Completed by 3 Widowed 4 Xivorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Furniture Restorer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Mary Hite Francis Schoenbauer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 219 Lees Lane, Edgewater, MD 21037 Thomas A. Schoenbauer / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/27/2012 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner ontogg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed the Abours after death.

2 Abours after death.

2 Abours after death.

3 After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 No Hospital: 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28d. Describe how injury occurred 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2/ Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 7 29d. Date signed (Month, Pay, Year) 29c, License number 29b. Signature and title of cer gx cause of death (Item 23a) (Type, Print) 30. Name and addre

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day,

NOVO

Year)

			Please '	Type or Pri									gible.		
			. For	State of Ma	aryland					and M	lental Hyg	iene	2 1 0	05000	
		_1	State Registrar			Cer	tificat	e of D	eath		R	eg. No.2	112	35690	
	Physicia	n/	1. Decedent's Name (First, Middle, Last	J. SIMMS 2. Date of Death Month Corresponding					Day	Year 20 12	3. Time of Death				
	Medic Examin	_	4a. Facility Name (if not institution, give s		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death				
	Exam.	9.	18636 Walker Choice F	Road					Gaithe	rsburg	,		Mont	gomery	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. la	st birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birthplace (State or Foreign Country)		
	Director		577-62-9127 1 [ Usual Residence of Decedent	<b>X</b> M 2□ F	67	Yrs.	Month				(Month, Day, 10/09	/1945	945 DC		
	e fied within 72 hours effer death with the Maryland field within 72 hours effer death with them "nature!", or items 23e or 28e-f show event, the Medical Examiner must be notified at	ē	10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits	
	Maryl 88a-f tiffee	Funeral Director	MD Montgomery Gaithersburg,											1 X Yes 2 □ No	
	oor S		10e. Street and Number 10f. Zip Code									10g. Citizen	of What Cou	untry?	
:	s 23	Jer.	18636 Walker Choice I	Road					208				US		
	item item		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic On n, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		lace - Amer lack, White		
36	offer i", or kamii	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X	No		1 🗌 Yes	2 🔀 No	Specify:			Spec	cify:	Black	
8	ature	Completed	15. Decedent's Ed	Year or Dates.	- 1	16a. Dece	dent's Usu	al Occup	ation			16b. Kind o			
15	72 h in "ni Medi	립	(Specify only highest gra	de completed)		(Give	kind of wo	rk done d	luring mos	t of work	ing				
212	within 72 hours effer death with the Maryland gjene. et then "nature!" or items 23e or 28a-f sho the Medical Examiner must be notified at		Elementary/Secondary (0-12)	College (1-4 or 5				Aı	nalyst				Ret	ail	
ğ	filed valled val		17. Father's Name (First, Middle, Last)						18. Moth	er's Nam	e (First, Middle, i	Maiden Suma	ame)		
/lar	ild be fil Mental Iarked etic ev	잍	Je	essie J. Simms	Jr.					_		Bessie			
an.	should be file and Mental is marked of reumetic eve	П	19a. Informant's Name/Relationship (Ty										City or Town, State, Zip Code)		
2	1 end 2 should by f Heelth and Men Item 27 is mark other treumetic		Tiffany Simms / Daugh	hter 5834 20b. Place of Dispos					enue. I		ashington,		OC 20011		
Ore	. 0	Ш	20a. Method of Disposition 1 Burial 2 X Cremation 3		other plac	e)				•					
Baltimore, Maryland 21215-0036	t. Pag timer rtent		4 Donation 5 Other (Specific		Chesapeake Crematory 11/7/2012  22. Name and Address of Facility							Beltsville, MD			
Bal	permit. Page Department Importent: Il eny injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Dorota Marshall  Maryland Cremation Services, PO Box 1413 Baltimore, MD 21												
			23a Part 1 Enter the disease, or comp	olications that caused	the death								Daitinio	Approximate	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition														Interval Between Onset and Death	
	nysician/ Medical		disease or condition resulting in death)	a. Due to (or as			700	_					-	(3 pour)	
-	Examiner														
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
	e executed sian and urial-transit	Examine	Cause (Disease or injury that initiated events	c											
	e execut ian and urial-trar	高 正	resulting in death) Last	Due to (or as	a consequ	uence oi):									
09	eath certificate be ettending physici I for use as the bu	giệ		d											
Box 68760	ertific ding p	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy						23d	Date of de	livery	
X	ath co	ciar	in the past 12 months?	1 Live Birth 4 Pregnant	2 Feta	al death 3	☐ Ectopic☐ Other (	pregnan	су				Month	Day Year	
œ.	y the	Physician/Medical	9 Unknown	9 Unknown			_				-				
P.O.	ires that the dea' signed by the el ild be detached f		Part II. Other significant conditions c	ontributing to death l	out not res	sulting in the	underlying	g cause g	iven in Parl	t I.				the cause of death?	
ds,	requires been sig should b	E E									10			robably 4 Tunknown	
Records,	aw ren as be	Completed by									24a. Was autoj	osv	4b. Were au prior to death?	topsy findings available completion of cause of	
Re	The law cate has page 2	ပြွ									perfo	2 <b>N</b> No		2 🗆 No	
tal	iician: The certificate irector, pag	a	25. Was case referred to medical examiner?	Hospital:				Ott			د only one)				
Ş	Physi this c ral dir	<u>P</u>	1 Yes 2 No	1 Inpat		ER/Outpation 28b. Time	_	DOA DOA	4 L N	Vursing H	ome 5 Resident			ify)	
O L	ding th. After fune	gte	1 PNatural 5 Pending 2 Accident Investigation	(Month, Da		injury	М	wor		□No	200: 200: 20	,,			
Sio	or Attencater death	Certificate:	3 Suicide 6 Could not b	28e. Place of in	jury - At ho	ome, farm, s	treet, facto	ory, office					ımber or Ru	ral Route Number,	
Division of Vital	ital or irs afte ai Dire	S		building, e						5)	City or Tov			<u> </u>	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical		iner On the basis of	examinatio	n and/or inve	stigation, i	n my opin	ion, death o	occurred a	at the time, date a	and place, and	due to the	cause(s) and manner stated.	
	To the vithin To the complex	Σ	only one) 3 LJ Certifying Nur 29b. Signature and title of certifier	//	no peat Of I	, MIOWEGY			se number	and p		29d. Date si			
			1 hand					D	467	-5		11/5	112		
	151		30. Name and address of person who		death (Iten	n 23a) (Type,	Print)	/mm/	· D	3	ET17657	in in	マ フ	0817	
	Sta	nto.	31. Date filed (Month, Day, Year)	CIA M	rar's Signa	110 12	عادل	9/6	7	111	e 170) /	7		UIT.	
	Regist		NOV 0 7 70	3. Regist	1	1. 100	Med	'	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 2, Physician/ 20 12 William Stone 12:15 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Edgemere 8610 Esquire Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral 7. Age (In yrs. last birthday) (Month, Day, Year) Days Hours Country) 212-40-2020 Director 1 XM 2 □ F 69 Maryland Yrs. September 8,1943 Usual Residence of Decedent r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Page 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Edgemere MD Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21219 USA 8610 Esquire Road 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dundalk Marine Terminal Crain Operator years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Kain Murray Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Stone Wife 8610 Esquire Road, Edgemere, Md. 21219 Department of Healt Important: If item 2 any injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 6, 2012 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connective Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Brain Physician/ metestesis disease or condition resulting in death) dul s Medical Due to (or as a consequence of) Examiner yea 5 409 Sequentially list conditions, if any, leading to immediate cause Extra Undarying Cause (Disease or injury Due to (or as a con uence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Nesidence} \) 6 \( \text{Other} \) Other (Specify) 2 DXNo 1 Inpatient 2 ER/Outpatient 3 DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, DOD74373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARULRAJAH 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Year Sterle November 3:52 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Stella Maris Hospice Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 216-34-8610 September 14,1936 Maryland 1 XM 2 □ F 76 Yrs. 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Dundalk 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 USA Funeral 1788 Brookview Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12)
12 years College (1-4 or 5+) Western Electric Plainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Hlabay John Sterle Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1788 Brookview Road, Dundalk, Maryland wife Barbara Sterle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory BAltimore,MAryland 2, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundiral Service Licensee Connelly Funeral Home of 7110 Sollers Point Road, Dundalk, P.A. Dundalk, Md. 21222 KONY 23a. Part 1. Enter the discusse or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi-resulting in death) PARKINSONS DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 24 hours after death. Fruit this certificate has been signed by the attending physician and Frunctal Director. After this certificate has been signed by the attending physician and letter fruit on the funeral director, page 2 should be detached for use as the burial-transletely filled in by the funeral director, page 2 should be detached for use as the burial-transletely filled in by the funeral director, page 2 should be detached for use as the burial-transletely filled in the filled filled from the filled filled from the filled filled filled from the filled fil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown 1 🔲 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🛣 No **Division of Vital** or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕷 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the h within 2 To the F only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TRACIE L. MORGAN, CRNP

State Registrar 31. Date filed (Month, Day, Year)

2012

STERLE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Leroy Stevenson 4:14 PM 2012Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 214-58-9225 60 Director 1X M 2 F Aug. 23, 1952 MD Yrs. Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after daath with the Maryland the Medical Examiner must be nutflied at Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA items 23a 2601 Boone St. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Ves 2 No Navy
If Yes, Give
Year or Dates 971-77 Black, White, etc. 1 Never Married 2 Married 2 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Navy 12th <u>Signalman</u> Be 18. Mother's Name (First, Middle, Maiden Sumame) aryland permit. Page 1 and 2 should be filed Dapartment of Health and Mantal Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) မှ Delores White Curtis Stevenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r) 2601 Boone St. Balto, Md. 21218 19a. Informant's Name/Relationship (Type, Print) Angelica Stevenson (daughter) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory or other place)

Garrison Forest Veteran .2012 1X Burial 2 ☐ Cremation 3 ☐ Removal from State OwingsMills, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licer 1412 F Preston St. Baltimere 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events the Hospital or Attending Physician: Tha law raquiras that tha death certificate be executed hin 24 hours aftar death. the Funeral Director: After this certificata has been signed by the attending physician and riplately filled in by the funeral diractor, paga 2 should be datached for use as the burial-transi. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Records. 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence 6 K Other (Specify) HOSPICE 1 ☐ Yes 2 💢 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical

To the within 2 To the compla

STEVENSON

LEROY

4:14

State

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed ca

2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRIVE 31. Date filed (Month, Day, Year) NOV 0

Registrar

use of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month,

TIMONIUM, MD 21093

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GERTRUDE NOVEMBER 04. 2012 SEIF 6:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTH OAKS BALTIMORE BALTIMORE Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) **Director** 064-16-8327 1 □ M 2 🗓 F 92 02/20/1920 NY Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WORKER STATE OF MARYLAND Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ EISENKRAFT ALBERT JOSEPHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN SEIF/SON 106 KINGFISHER LANE, NEW HARTFORD, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP 11/06/2012 TOWSON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death

Month Physician/ tallure Medical resulting in death) Due to (or as a consequence of) Examiner Debili Sequentially list conditions, Examine Due to for as a consequ cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 nding p IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 - Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 5,2012 037573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Neelis Box Salibbuy 21802 Scf 100 MO

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 4 Physician/ 2012 STEIN 08:20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL CROFTON CARE & REHAB CENTER CROFTON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 098-16-8728 1 □ M 2 🛛 F 91 09/26/1921 NY Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 X No MD ANNE ARUNDEL CROWNSVILLE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 1202 JOHN ROSS COURT 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event; the jonce. the SECRETARY HEALTHCARE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည MYER LEVY FLOSSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLAN STEIN/SON 1202 JOHN ROSS COURT, CROWNSVILLE, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 Cremation 3 X Removal from State MOUNT ARARAT 11/06/2012 FARMINGDALE, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or comp shock, or heart failure. List only scations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e cause on each [rie.] Immediate Cause (Final Onset and Death Physician Cellice disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ring Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 06-2011

Registrar

31. Date filed Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER Physician/ SAGEL ARI FNE 02 2012 12:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 12/19/1932 219-28-7387 Director 1 □ M 2 🔽 F 79 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho Director BALTIMORE MD **BALTIMORE** 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** USA 21208 5 MARY CARROLL COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHI TE 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 end 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) JOPPA LIQUORS OWNER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNA SWICKERT ROSENSWEIG SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 MARY CARROLL COURT, BALTIMORE, MD 21208 DANIEL SAGEL/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or BALTIMORE HEBREW CEM. 11/04/2012 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign wurn of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physician and I for use as the burial-transit or Attending Physician: The law requires thet the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) a | Linknown certificate has been signed by ifirector, pege 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 D Other (Specify) SPECE 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 06-2011

Registrar's Signa

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35697 State Registrar Reg. No. 4 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ NOVEMBER 11:55P M IRVIN SOBER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE RANDALLSTOWN 8900 MEADOW HEIGHTS ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday **Funeral** Director 216-09-3488 1 X M 2 □ F 97 07/28/1915 MD Usual Residence of Deced or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State with the Maryland must be notified at Director 1 Yes 2X No MD BALTIMORE RANDALLSTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a USA 21133 8900 MEADOW HEIGHTS ROAD . Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Yes. Give Specify: WHITE Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) OPTICIAN OPTICAL Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ SOBER MOLLY FELDMAN HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 MEADOWSWEET ROAD, PIKESVILLE, MD 21208 DENNIS SOBER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CONG. 11/04/2012 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Lice PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year be detached for 5 Other (specify) Pregnant at time of death Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of death? 2000 24a, Was an autopsy perfor 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Other (Specify 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d, Describe how injury occurred Manner of Death Matural 5 Pending Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I

29b. Signature and title of certifie

ROBERT KROOPNICK,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

4000

32. Registrar's Signature

OLD

Registrar DHMH 17 Rev 06-2011 COURT

29c. License number

#300

SUITE

ROAD,

29d. Date signed (Month, Day, Year)

PIKESVILLE.

		Pleas	se Type or							_		_	e.		
		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death Reg No 2 0 1 2 3 5 6 9													
		Registrar  1. Decedent's Name (First, Middle,	I ast)			Certi	ricate or	Death		2 Poto of D	Reg. N	lo./	2	لحيا	<u> 598</u>
Physicia		ED ANY COLLEDD									ar	3. Time of			
Medic Examin		4a. Facility Name (if not institution,	give street and nur	nber)			4b. City, Town,	or Location	of Death	INOV	4	c. County of E	_	07.3	173
		SINAI HOSPITAL	OF BALTIN	lone			BALTICA					·	N/	Ά	
Funeral		Social Security Number	6. Sex		yrs. last birth		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bi (Month, D		9.	Birthpla Country	ce (State o	or Foreign
Director		214-03-5299 Usual Residence of Decedent	1 🕅 M 2 🗆 F		94 <sup>Y</sup>	rs.		1		05/29	/19	18		MD	
shov	tor	10a. State 10b. County	Ē	100	. City, Town	or Loca	tion						100	d. Inside C	ity Limits
Mary 28e-1	Director	MD N/A			BALTI	MORE	Ε							1X Yes	s 2 🗆 No
hours after death with the Maryland hours after death with the Maryland natural", or items 23a or 28e-f show the Examiner must be notified at	al D	10e. Street and Number					10f. Zip Code				17	Citizen of What	Country	y?	
ath wi	Funeral	2700 JEREMY CO	URT, #D	ident Ever i	n 11 S	13 Wa	21209 as Decedent of		rigin? (Sp.	acify Vac ar Na		USA		1-10-	
er de	by F	1 ☐ Never Married 2 💢 Marrie	Armed Fo	Armed Forces? 1 ☑ Yes 2 ☐ No			es, specify Cut	oan, Mexic	an, Puerto	Rican, etc.)		14. Race - A Black, W			
urai",		3 Widowed 4 Divorced	If Yes, Giv Year or D	If Yes, Give Year or Dates.			1 ☐ Yes 2 🖾 No Specify:					Specify: W	HITE	Ξ	
27	Completed	15. Decedent (Specify only highes			11 (	Give kin	nt's Usual Occu nd of work done	during mo	st of work	d <b>n</b> g	16b.	Kind of Busine	ess/Indu	stry	
within 72 giene. er then ",	Con	Elementary/Secondary (0-12)	College (1	-4 or 5+)		ife. DO i	NOT use retired ROUTE	•	SMAN			Τ.ΔΙΙ	NDRY	7	
fled w Il Hyg I othe vent,	Be	17. Father's Name (First, Middle, La	est)		- 1		ROOTE	T		ne (First, Middle	, Maide		IIDIC.	<u> </u>	· ·
d be f Menta arked aric e	욘	ISADORE	SCHE	ERR		CE	CILI	A		$P^{A}$	UL				
12 should be filed within 7 12 should be filed within 7 127 is marked other then r treumetic event, the M		19a. Informant's Name/Relationshi			19b.	Mailing	Address (Stree	t and Num	ber or Run	al Route Numb	oute Number, City or Town, State, Zip Code)				
and 2 s Health em 27 ther tre		IRENE SCHERR/W 20a. Method of Disposition					2700 JEREMY COURT, #							t, MD 21209 ation - City or Town, State	
age 1 t: If it		1 X Burial 2 Cremation			cemetery	, crema	tory or other pla								
ank. Poertme	17	4 Donation 5 Other (Sp 21. Signature of Funeral Servature			ANSI		IESEN Name and Addr					ROSEDAI			
permit. Page 1 and 2 in Department of Health Importent: If item 27 eny injury or other tr	l di	► Michael	MILLEN				3900 RE						-		208
		23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that	caused the	death. Do no	t enter t	the mode of dy	ing, such a	s cardiac	or respiratory a	rrest,		A	pproximat	te
Pnysician		Immediate Cause (Final disease or condition			CCAL I	NE	MONIME	SEPY	1 51	40cm				nset and	Death
Medical Examiner		resulting in death)	Due to	(or as a cor	sequence of	):	2-0-0-2-1-1-14-2-0								
	ř	Sequentially list conditions,	b. 5745	VTUC .	CCAL	BA	CTENEM	IA					u	DAYS	
ecuted and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CCAL	CAL PNEUMOMA							4	pry	5		
exectalan an	_	resulting in death) Last			sequence of										
ate be hysici the bu	Physician/Medical		d							. <u></u>			+	_	
ertifica ding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c, If yes, ou	come of pr	egnancy										
eath o	icia	in the past 12 months?	1 Live	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)								23d. Date of Month			Year
the d by the tacher	hys	9 🗆 Unknown	9 Unk												
s that igned be de		Part II. Other significant condition					, ,		t I.			use contribut	/		
equire een si hould	eted	NON BY ELENATION	MYOCA	UDIAL	INFAI	227	ION A	MJE				2 No 3			
law i has b	Completed by	WBULAR NECK	0515							24a. Was	s an opsy formed?	24b. Were prior deat	to comp	y findings a pletion of c	available ause of
n: The ificate or, pa		25. Was case referred to medical					26	Diago of Do	oth (Chan	1 🗌 Yes			Yes 2	ØN₀	_
ysicie is cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient	2 🗌 ER/Out	patient		her:		k only one) ome 5 ☐ Res	idence	6 ☐ Other (S	neciful		
ng Ph fter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date		28b. Ti		28c. Inju	ıry at	var outing 7 h	28d. Describe			<u></u>		
or Attending Physicien: The law requires that the death certificate be explicate, and death certificate be explicated. Birector: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the burial	Certificate:	2 Accident Investige 3 Suicide 6 Could n	ation				M 1	Yes 2	□No				-		
To the Hospital or Attending Physicien: The law requires that the death certificate be ex within 24 hours after deeth.  To the Funerei Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria		4 Homicide determined 28e. Place of Injury - At nome, farm, street, factory, office 28f. Lo							28f. Location City or To		nd Number or le)	Rural R	oute Numb	ber,	
To the Hospital within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifying I	Physician: To the base	est of my k	nowledge, d	eath occ	curred at the tir	ne, date an	d place, a	and due to the	cause(s)	and manner a	s stated.	(a) and ma	noor stated
the H thin 24 the F mplete	Me	only one) 3 L Certifying I	Nurse Practitioner	: To the bes	t of my know	ledge, de	eath occurred a	the time, o	late and pl	ace, and due to	the caus	se(s) and mann	er as sta	ted.	inner stated.
<b>6</b> ≥ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5 ≤ 5		29b. Signature and title of certifier					29c. Licen	se number - 000				ate signed (Mo			
mali		30. Name and address of person w		se of death	(Item 23a) (Ti	ne Pri-		000			NO	VEMBER	< 1, ·	2012	
F10,		ASITRIT MULT					OSPITAL	OF R	SALTI	MOYLE					
Stat		31. Date filed (Month, Day, Year)		egistrar's S											

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 252 am Physician/ ovembe Medical 4a. Facility Name (if not institution, give street and number 4b, City, Town, or Location of Death 4c. County of Death Examiner etimore 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Ade (In vrs. last birthday) Funeral 57 Months Hours Min 1 ▼M 2 □ F 14-64-0036 irginia **Director** 28a-f show 10a State 10c. City, Town or Location ŧ 10b. Count 10d. Inside City Limits Director must be notified 1- Yes 2 No MOYR 0 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A 802 2/2/7 items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Specify: Black 3 Divorced 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname ဂ္ Jar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number r Rural Route Number, City or Town, State, Zip Code) Moh 20b. Place of Disposition (Name of cemetery, crematory or other p od of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signal 22. Name and Address of of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Que to (or as a consequence of) Examiner entral Nervous Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury remice the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 $^<$ attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a Id be detached f 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Drabetic 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsv this certificate has page 2 perform death? 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 □ Yes 2 □ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pendina Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 1 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. ander

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Robert J. Simpkins, Sr. 4:12 PM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours (Month, Day, 73 **Director** 224-56-1679 1939 Virginia lug. Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 45 Glen Dale Road 21061 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 X Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business Industry and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Roscoe Simpkins Elizabeth Edith Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and a common Department of Health an Important: If item 27 is Robert J. Simpkins, Jr/Son 325 Tulip Oak Court, Linthicum, MD 21090 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/05/2012 Glen Burnie, Maryland Glen Haven Mem. Park 22. Name and Address of Facility Kirkley-Ruddick Funeral Home a I Se 21. Sign 0 421 Crain Highway SE, Glen Burnie, MD 21061 23a. Part 1: Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Records, No 3 Probably 4 Unknown 1 Yes Completed avdio myapath 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 - ER/Outpatient 3 - DOA မ this 28a. Daje of injury (Month, Day, Year) funeral Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director; A completed filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Dcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur d title certif

Registrar

State

me and address of

7

death (Item 23a) (Type, Print)

leted cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRAXTON TOBE 201 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIM NOSPITAL RANDALISTOWN NINTHWES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Min MD Director 28a-f shov with the Maryland 10a. State 10b. County Town or Location 10d. Inside City Limits notified at Funeral Director 1 Yes 2 No tomore 10e. Street and Number 10g. Citizen of What Country? 6 10f. Zip Code ms 23a or must be n permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Army Specify: ac Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MI mora 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Normation 3 Removal from State altimore 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Jaren. 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2. No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No \_\_ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar RPAP.

RANDAL

1550 NO MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401

020

COYST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ IIn 2012 Medical ta. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ellicott lace Howa HOLLOW If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 1 M 2 14 orea 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Completed by Funeral Director 1 Nes 2 No licott 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? DI 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only high grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kwano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other. Baltimore, Method of Disposition

Derial 2 Greenation 3 Removal from State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory 4 Donation 5 Other (Specify) lane 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician/ Thrius moulas disease or condition Medical resulting in death) moully Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed hermers Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce 29c. License number D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COWMBIA LANE 6336 Q ABBAS 31. Date filed (Month, Day State NOV Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State	of Marylar	nd / Depa	artment	of Heal	th and I	Mental Hy	giene	010	0 - 7 0 0		
			1 - State Registrar Certificate of Death									Reg. No. 2012 357				
П	Physicia	ın/	1. Decedent's Name (I									ath Dav	Year	3. Time of Death		
	Medic	cal	An Facility Many Com		Thompson  4b. City, Town, or Location of Death					t 27, 20		10:00 A M				
	Examir	er	4a. Facility Name (if no		4b. City, To		tion of Death <b>Iumbia</b>		4c. Co	unty of Death Hov						
	Funeral		5. Social Security Num	_	ursing Ho	7. Age (In yrs.	last birthday)	If Under 1		nder 24 Hrs.	8. Date of Birt	th		place (State or Foreign		
н	Director		215-32-20	60	I □ м 2 <b>⊠</b> F	91	Yrs.	Months E	Days Ho	urs Min.	(Month, Day	y, Year) <b>1, 1921</b>	Coul			
	D 00 #	L	Usual Residence of I	Decedent 0b. County		100 0	ty, Town or Loc	ation			l			40.1.1.1.00.11.0		
	arylan a-f sh	Director	MD .		ward	100.01	ty, fown or Loc	ation	FIli	cott City				10d. Inside City Limits 1 ☐ Yes 2 🗹 No		
	or 28		10e. Street and Numb					10f. Zip Co		-		10a Citizen	of What Cou			
	with t	Funeral	8720 Ridge F	Road						1043		rog. omizon	U.S.A			
	ltems er m	Fun	11. Marital Status		12. Was Dece	edent Ever in U.		Vas Deceden Yes, specify	t of Hispani	c Origin? (Sp	ecify Yes or No-		Race - Ameri			
36	after of	ğ	1 Never Married			2 X No		Yes 2			riican, etc.j		Black, White, cify: <b>Whi</b> t			
8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Evamirer must be rectified at	Completed by	3 Widowed 4	Divorced  15. Decedent's I	Year or D	ates.		ent's Usual C								
75		ם	(Specif	y only highest g	rade completed		(Give I	aind of work a NOT use re	lone during	most of work	ing	16b. Kind o	of Business/Ir	idustry		
27	within giene. er tha		7	Jary (0-12)	College (1	-4 Or 5+)		Н	omema	ker			Own H	ome		
pu	e filed within nated Hygiene.	To Be	17. Father's Name (Firs	, , ,					18. 1	Mother's Nam	e (First, Middle,		•			
3	should be fill and Mental is marked craumatic ever	-			Villiam A.	nompsor	) 				Marga	aret Ann	Cavey			
Ma	VI + 1		19a. Informant's Name		Type, Print)						al Route Number icott City, I			Code)		
ē,	Hea Hea ther		20a. Method of Dispos			20b.	Place of Dispor			1	Date Dity,		on - City or T	own State		
E O			1 ⊠ Burial 2 ☐ 4 ☐ Donation 5			State	cemetery, crem	atory or othe	r place)	1	02, 2012		Ellicott C			
Baltimore, Maryland 21215-0036	permit, Pega Depertment of Important: If any Injury or once.	١,	21. Stonature of Funeral Survice Liverses 22. Name and Address of Facility										2 10 10			
<u> </u>	88 = 88	1	Melor	Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043												
			23a. Part 1. Sofer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.									rest,		Approximate Interval Between		
2	Pnysician	10	Immediate Cause (Final disease or condition Onset and D										Onset and Death			
	Medical Examiner		resulting in death)  Due to (or as a consequence of):													
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										-			
	uted d ansit	ami	Cause. Enter Underlyi Cause (Disease or inju- that initiated events	ng 💽												
	exec	Ě	resulting in death) Las	st	Due to	(or as a conseq	uence of):									
90	sete be executed physician and the burlal-transit	dical Examine			d											
687	artifica ding p		IF FEMALE:		23c If were out	come of pregna	anov				_					
Box 687	death cartific he attending p led for use as	cian	23b. Was decedent pre in the past 12 mg	orths?	1 🔲 Live	Birth 2 Fet	al death 3	Ectopic pred				23d.	Date of deliv Month	ery Day Year		
B	he de y the ached	hysi	1 Yes 2 1 9 Unknown	No .	9 🗌 Unki			Curci (Speci	·//							
Division of Vital Records, P.O.	requires that the death cartific been signed by the attending p should be detached for use as	by Physician/M	Part II. Other significa	ent conditions	ontributing to d	eath but not re	sulting in the u	nderlying cau	se given in	Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?		
ds,	quires en sig ould b	ted	<del></del>								10	res 2 N	o 3□Pro	bably 4 🗌 Unknown		
CO	aw reas be	ple									24a. Was a	an 24	b. Were auto	psy findings available		
Re	The Cate h	Completed						_			perfor	med?	death? 1 ☐ Yes			
ital	iclan: certific	B	25. Was case referred examiner?	•	Hospital:			2		Death (Chec	k only one)					
\_\	Phys this ral di	5	1 Yes 2 2	No	1 🗆 28a. Date	Inpatient 2  of injury	ER/Outpatien 28b. Time of		Other: 4.	Nursing Ho	ome 5 Resid			)		
n c	nding tth. : After a fune	cate		5 Pending Investigatio	(Mon	th, Day, Year)	injury		work?	2 □ No	28d. Describe h	ow injury occ	curred			
isic	Atter ector by th	Certificate:		6 Could not be determined	e 28e. Place	of Injury - At he	ome, farm, stre				28f. Location (S		mber or Rura	l Route Number,		
Š	italor irs aftu al Dir led in				buildi	ng, etc. (Specif	<i>"</i>			- 1	City or Tow	n, State)		1		
	Hospi 24 hou Funer tely fil	Medical	(Check 2 L	i Medical Exam	ment On the bas	sis of examinatio	n and/or investi	gation, in my	opinion, dea	th occurred a	nd due to the ca	nd place, and	due to the ca	use(s) and manner stated		
	To the Hospital or Attending Physician: The law requires that the within £4 hours after death.  To the Funeral Director: After this certificate has been signed by ti completely filled in by tha funeral director, page 2 should be detach		only one) 3   29b. Signature and title	Certifying Rur	se Practitioner	: To the best of i	my knowledge,	death occurre	d at the time	e, date and pla	ace, and due to the	ne cause(s) ar	nd manner as	stated.		
	⊢s⊭ŏ		•	/1/	MD			174	744	(7		CO CL	ned (Month,	7012		
J	Jan		30. Name and add	person who	completed caus	se of death (Iten	n 23a) (Type, P	rint)	. ,	-		UCTO		1		
	20		And	(97115	633	34 (	day lo	ivy	Col	cub	14 N	195	19 md.	Day, Year)		
	Stat	-	31. Date filed (Month, L		9 82. R	egistrar's Sign	ture bas	1								
	Registra	iř.	NUV	0 7 201	- sen	un po	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Month Day 151 LINDRE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Augsburg Lutheran Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🛛 F Days Months Hours Min Director 040-18-1685 92 Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No MD Baltimore Gwynn Oak ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 6811 Campfield Road 21207 U.S.A. - Page 1 and 2 should be filed within 72 hours after death irrent of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaking Own Home ed other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Wrobell Leona Wroblski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Tykson-Pujia (daughter) 953 Sablewood Road - Apt. C - Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn. 11/07/2012 Fallston, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. <u> 11750 Belair Road - Kingsville, MARYLAND</u> 21087 23a. Part 1. Enter the disease, or complication; that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CUTTE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of: Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, Mu)

Registrar DHMH 17 Rev 7/2009

State

lov

P.0

MILLS MD 21117

WINGS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's

31. Date filed (Month, Day, Year)

NOV 0

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) NOV 0 7 2012

001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THOMPSON Physician/ Nonth VOV ay 2042 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours January 30, Director 316-12-3036 1 🕅 M 2 🗆 F 90 1922 Kansas 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
I them 27 is marked other than "natural", or Itema 23e or 28a-f show other traumatic event, the Medical Examination to the profiled at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21209 5807 A Western Run Drive America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3℃Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 is and Mental Hyglene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Savings and Loan Loan Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elva Funkhauser Frank Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5807 A Western Run Drive Baltimore, Maryland 21209 Cheryll A. Cooley/ daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Depertment of I important: If its eny injury or of November 7, Evans Funeral 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Forest Hill, Maryland Bel \_Air 21. Signature of Fineral Service Licens 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ rosta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate raus. Find I had rainy Cause (Disease or injury Due to (or as a consequence of): Examir signed by the ettending physician end d be detached for use es the burlel-transit or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 10 No 3 ☐ Probably 4 ☐ Unknown Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funerel director, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 1 Tyes **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Hospital 2 No 1 🗌 Yes |၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No М ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cause of death (Item 23a) (Type, Print) 31. Date filed (Morith, Day, Year) State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day . Ronald Anthony Thomas 2012 November 4:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6412 Wilson Street Glen Burnie Anne Arundel Co. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Director 219-34-2138 1 🛛 M 2 □ F Yrs. 72 03/28/1940 Maryland Usual Residence of Deced show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6412 Wilson Street 21060 U.S.A. 12, Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. **Black** Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Specialist United States Army 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Nea1 Elsve Mae Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 6412 Wilson Street Mrs. Patricia Thomas / Wife Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 11/14/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1479 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Lice Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ģ Pregnant at time of death signed by the a d be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2  $\square$  No 1 🗌 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No Be 26. Place of Death (Check only one) Hospital မ ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 Inpatient 2 After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State, 24 hours a Funeral I within 24 hou

To the Funer

completely fil 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar 29d. Date signed (Month, Day, Year) 50470 06

Registrar

DHMH 17 Rev 06-2011

State

SRIDHAR

31. Date filed (Month, Day, Year)

NOV 0

Cilclus

#800

Gren Burnie MD 2106)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATLURI

7310

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOVEWBER 8:21 AM Henry C. Tolker 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Agues HOSPITAL BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 219-18-1471 Director 1 X M 2 □ F 88 Usual Residence of Decedent March 28, Maryland ul Hygiene. I other then "neturel", or items 23e or 28a-f show vent, ihr Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Rumford Drive Unit 101 **USA** 21228 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 7 Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Office Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 1 end 2 should be file of Health end Mentel H I Item 27 is marked of cother traumetic ever မ Henry C. Tolker Edith Trott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue A. Schenning, Daughter Hay Pasture Court Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pege 1 permit. Pege 1
Department of Important: if it eny injury or o ₽ 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory <u>Inc.</u> 11/05/12 Baltimore, Maryland 22 Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licensee Thomas Gregor and 21228 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death HENMONIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTION Bower Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{ Other (Specify)} 2 No မ 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 MOWHBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIHORE 32. Registrat's Storiatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Curtis Toney 2012 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 225-62-7125 Director 66 1 M 2 D F Oct. 19, 1946 Virginia Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 0a. State 10c. City. Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 No Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1234 Farragut Place NE 20017 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of 2 Department of Health and Ment; Important: If Item 27 is marked any injury or any injur Clarence Toney Daisy Scruggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1234 Farragut Place NE Washington, DC 20017 - Companion Minnie McDonald Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Toney Family Cemetery 11/10/2012 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Canton, VA Metropolitan Funeral Service 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee Alexandria, VA 2231 5517 Vine Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events for as a cons Exami burial-transit Due to (or as a consequence of); resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, cate has been sig Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 V No မ 1- Inpatient 2 ER/Outpatient 3 DDA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue Takoma Park, MD Padma Chirumamilla, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NUA U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year William, C, Thurston **Physician** 11:02 AM 03 2012 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baitmore Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🕱 M 2 🗆 F 212-34-4410 74 Director Dec. 10.1937 Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director MD Baltimore Baltimore Co 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 7923 Eastdale Road 21224 Funeral United States permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" any injury or other traumatic exercise. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ▼ Yes 2 [ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 🕅 No Specify. Specify: þ 3 Widowed 4X Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 10 Years Signode Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Burch ဂ Milton Thurston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Norman L. Thurston (Brother) 101 Longwood Ave. Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 11/6/2012 4 Donation 5 Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee Michael L. Neiser<sup>22.</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. (les 1.uha 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** Small Cancer cell Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Live birth 2 Fetal death Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, should be 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 2 certificate has 1 Tyes 2 No 1 TYes or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Alnpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ၉ after death.

Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many er stated. (check only 29d. Date signed (Month, Day, Year) re and title of certifier 29c. License number 11,03,2012

State Registrar 31. Date filed (Month, Day, Year)

7 2012

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:00 p<sup>M</sup> Harold Taylor James October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George's 12230 Old Colony Drive Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days July 7, 1926 Maryland **Director** 703-07-9862 1 🔀 M 2 🗆 F 86 Yrs. Usual Residence of Deced or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Upper Marlboro MD Prince George's 10f. Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be Funeral USA 12230 Old Colony Drive 20772 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates.1945–46 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: init. Page 1 and 2 shourd ...
nartment of Health and Mental Hygiene.
" Hem 27 is marked other than "natura, ...
" matic event, the Medical Ex 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Circuit Court Judge 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Milton Tavlor Margaret Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tranonce. 12230 Old Colony Drive Upper Marlboro, MD 20772 Jan Taylor/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place, 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Final Journey Crematory 11/03/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signatur Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Decompensated Congestive Heart Failure disease or condition resulting in death) Medical **Examiner** Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pulmonary Hypertension Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Diabetes Mellitus Type II Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached a Hinknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 🗌 Yes 2 🔲 No Yes 2 X No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 3No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 1 XNatural 5 Pending work s after death.

I Director: Af
d in by the fu 1 🗋 Yes 2 🗌 No Accident
Suicide Investigation the Funeral Directory filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar DHMH 17 Rev 06-2011

State

and tit

John H. Wills, M.D. 31. Date filed (Month, Day, Year,

2012

NOV 0

...

32. Registrar' Signatu

and address of person who completed cause of death (Item 23a) (Type, Print)

17005038

14310 Old Marlboro Pike Upper Marlboro, MD 20772

29d. Date signed (Month, Day, Year,

Z

12-08137 Catherine Marie T	etlo	Please Typow St	pe or Print in ate of Maryla	nd / Depai	tment o	of Health ar	<b>re All Copi</b> nd Mental H	<b>es Are Leç</b> lygiene	gible. 2012	35712	
	R	- For State tegistrar		Cert	ificate d	of Death			eg. No.		
Physiciar Medical Examin	1/	<ol> <li>Decedent's Name (First, Midd</li> </ol>	ne,Last) arie Tet	low				2. Date of Deat Month October 20	Day Year 6, 2012	3. Time of Death 2157 hrs	
	1	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7710 Pheasant Ridge Drive 4b. City, Town, or Location of Death 4c. County of Death									
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. la:		If Under 1 Ye  Months Da		n.	Foreig	thplace (State or gn Washington puntry) TC	
		219-76-0024 Usual Residence of Decedent	1M 2_A_F	53				1 09/08	3/1959	10d. Inside City Limits	
nd show any ice.		10a. State 10b. County  MD Mont	gomery _		rown or Loc ntaome	ry Villa	ge			1 Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number				10f. Zip Code		0g. Citizen of What Cou	ntry?		
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Health and Mental Hygiene. 11 If item 27 is marked other than "oatural", or items 23a or 28a-f sho other fraumatic event, the Medical Examiner must be notified at once.	— L	9576 Fern Hold  11. Marital Status  1 Never Married 2 N	12. Was Dec	edent Ever in U.S prces?			lispanic Origin? ( S an, Mexican, Puert			ican Indian, Black,	
ifter deat	by Fun		1 Yes	2 🔀 No	1					Mite	
21215-0036 Uld be filed within 72 hours after death wi Mental Hygiene. marked other than "oatural", or items cevent, the Medical Examiner must be		15. Decedent's Education (Specific Elementary/Secondary (0-12)					eation (Give kind of fe. DO NOT use re		16b. Kind of Business	'Industry	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Completed	12 17, Father's Name (First, Middle	e Last)		Hou	<u>isekeeper</u>	18.Mother's Nam	ne (First, Middle, M	Hospit Maiden Surname)	ality	
1215. be filed ental Hy rrked of	Be	James Ter	<b>√</b>		1		Doris		ettstat nber, City or Town, Stati	a. Zin Codo)	
MD 2. hd 2 should alth and M m 27 is m; sumatic e	٩	19a. Informant's Name/Relation  Jaime Cook / I			9576	Fern Ho	11ow Way		omery_Villa	ge, MD 20886	
Baltimore, MD 21215-0 permit. Pages I and 2 should be filed w Department of Health and Mental Hygis Important: If iten 27 is marked other injury or other traumatic event, the injury or other event, the injury of the injury or other event, the injury or other event, the injury or other event, the injury of the injury or other event, the injury or other event, the injury or other event, the injury or o		20a. Method of Disposition  1 Burial 2 Crematic				osition (Name of o other place)		Date	20c. Location - City of		
Baltimore, permit. Pages la Departiment of He Important: If its important: If its iojury or other the	ŀ	4 X Donation 5 Other S 21. Signature of Funeral Service		Ana		fts Regist Name and Addre			<u>  Hanover,</u> Gifts Regis		
m ងួក្ខី ្ទី Physician	4	23a. Part I. Enter the disease, o	r complications that ca	aused the death.	Do not ente	7522 Conn r the mode of dyin	nelley Dr g, such as cardiac	.,Ste. I	P, Hanover, rest, shock, or heart	Approximate Interval	
/Wedical Examiner	i	failure. List only one caus Immediate Cause (Final diseas	e on each line. e    a. <b>Athero</b> :	scleroti	c Car					Between Onset and Death	
		or condition resulting in death) Sequentially list conditions,	b	consequence of							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C	consequence of							
and and	ᇹ	022 11 1/ 12									
60, ate be exe hysician a	Medic	X UNPENDED  IF FEMALE:	23c. If yes,	outcome of pregr		per me,g			23d. Date of delive		
cords, P.O. Box 68760, law requires that the death certificate be exhabsen signed by the attending physician 2 should be detached for use as the burnal 2 should be detached.	Physician/Medic	23b. Was decedent pregnant in past 12 months?  1  Yes 2 No 9 ✓ U	4 Pregr	ant at time of dea	2	Fetal death  Other (Specify)	Ectopic preg	nancy	Month	Day Year	
P.O. E es that the (igned by the detached	ক্র	Part II. Other significant cond	Itions contributing to	ing to death but not resulting in the underlying cause given in Part I.					obacco use contribute to s 2 No 3 Pro		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be within 24 hours after death.  To the Fuoeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Completed							1 Yes		utopsy findings available completion of cause of	
Vital ysiciao: his certii	å	25. Was case referred to medic examiner?  1 ✓ Yes 2 No	20.0	Inpatient 2	ER/Outpati		Other Nurs		Residence 6 🗸 Othe	er: Scene	
Division of Vital Rec pital or Attending Physiciae: The I ours after death. reral Director: After this certificate I filled in by the funeral director, page	Certification: To	27. Manner of Death  1 X Natural 5 Pe	nding	of Injury n, Day,Year)	28b. Time	· · ·	njury at Work? Yes 2 No	28d. Describe	28d. Describe how injury occurred		
Divisior  al or Attend s after death Director:	rtifica	3 Suicide 6 Co	estigation uld not be ermined (Specify)		ome, farm, s	treet, factory, offic	e building, etc.	28f. Location ( or Town, \$		tural Route Number, City	
Divis  To the Hospital or A within 24 hours after To the Fuocral Dire completely filled in b	Medical Ce	4 Homicide  29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be	st of my knowledg of examination a	ge, death oc nd/or invest	curred at the time,	, date and place, a ion, death occurre	nd due to the cau d at the time, date	ise(s) and manner as sta e and place, and due to t	ated. the cause(s)	
To To Com	Med	29b. Signature and title of certi	and manner s	stated.		- ·	ense number		29d. Date signed (M October 27, 20		
		30. Name and Press of Person	on who completed cau	se of death (Item	23a)		C.M.E. ore Street, Ba	Itimore MD 2			
St	ate	Pamela E. Southall, 31. Date filed (Month, Day, Yea NOV 0 2012		egistrar's Signatu	ıre .	OU VV. Dailim					
Regist		NUV U 7 2012	Cknew	A. Da	Me						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e, per fh, 2933 11-7-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. cedent's Name (First, Middle, Last 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MILFORD MANOR PIKESVILLE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. **Funeral** Hours Months Director 113-78-8289 1 □ M 2 🛛 F 12/22/1925 86 UKRAINE Usual Residence of Decedent item 27 is marked other then "natural", or items 23a or 28a-f shov other traumetic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mill MANOR ROAD Funeral 21208 4204 OLD MILFORD USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: WHITE If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If Item 27 is marked oth any injury or other traumetic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 ZINA UNKNOWN OHKMAN DAVID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 KNOB HILL PARK DRIVE, REISTERSTOWN, MD 21136 MIKHAIL TRAKHTMAN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ARLINGTON CEMETERY CHIZUK AMUNO 1 X Burial 2 Cremation 3 Removal from State 11/06/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Que to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manny of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural
Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOB 31. Date filed (Month, Day, Year) State Registrar <u> NNV 0</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :10 P Milton Eddie Turner 11 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Kline Hospice Center Airy Mount Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 12/14/1941 Hours 403-54-2222 **Director** 1**X** M 2 □ F 70 KY Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🂢 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral RR5 Box 7 26726 USA items ? within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black White etc. should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or 1 Never Married XXMarried þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Wietnam Specify: white Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Secondary (0-12) US Army Colnel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Olin Edward Turner Dorothy Newberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau. Margaret Turner wife RR 5 Box 7 Keyser WV 26726 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State East End Cemetery 11/5/12 Cadiz KY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harman 21. Signatur Funer Service Licensee Funeral Service PA Glen Burnie MD 21061 7221 Grayburn Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to ( r as a consequen of) **Examiner** Sequentially list conditions also to forces e nonseguende off cause. Enter Underlying Cause (Disease or injury Exami and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown by ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perforn 1 Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: Natural 5 Pending injury s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 068 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring ( 31. Date filed (Month, Day, NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18, per fh, e933 11-14-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 15:00 PM **Physician** MARGERINE S. ,2012 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 13, 1 NIA Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months GA 1 🗆 M 2 🕟 74Yrs. 257-56-442 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show notified at 1 Nes 2 No **Funeral Director** more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 23a or the Medical Examiner must be 21213 permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If filem 27 is marked other than "natural" any injury or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status 12. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ò Q Slac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bundrige Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 860 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 ☐ Removal from State tomas 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Man Brehms MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** EMBOLUS ULMONARY DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4 - Pregnant at time of death 5 Other (specify) should be detached the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 🗌 No Yes 2 No 1 🗌 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 \sum Nursing Home Hospital: 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 🗆 No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) completely and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2012 OVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 11:40 A. M Hilda Amenda Unkart 2012<sup>Year</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford County Forest Hill Forest Hill Health & Rehab 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Director 217-12-9813 90 Sept. 20, 1922 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Madical Exeminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Churchville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21028 United States 430 Priestford Road death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: and Mental Hygiene. Is marked other than "natural", Specify: White Completed 3 √ Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Heath and Mental F Important: If Item 27 Is marked o any Injury or other traumatic even <u>ones</u>. Pearl Elizabeth Shanklin Phillip Eck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7888 Woodbine Road, Airville, PA 17302 Albert H. Unkart (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Nov. 8, 2012 Evans Funeral Chapel Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and I for use as the burial-transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 2 DW Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

GI LACE

32. Resistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ullman 2:07 AM hristopher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Examiner Whiteford Road Whiteford Social Security Number If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours 72 5936 Director 1 M 2 D F Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner inust be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford White ford 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral White USA 21160 tova Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No White 3 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4 or 5+) Verizon Office Technician æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ leanor Wienecke Lichard Ilman Car 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd., Whiteford VIlman (Wife Whiteford A. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other p 20c. Location - City or Town, State Date 1 Durial 2 M Cremation 3 D Removal from State 19019 Funeral Chape Forest Hill, MI) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Cremation Services - Bel Air Forest NewDOCK Drive Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani BRain disease or condition resulting in death) UM DR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and fittle of certifier MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) utherville HD 21023 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 0925 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 3265 Florence Road If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) 20. 24, 1920 Days Hours Min. Michigan 91 381-16-5230 Director 1 □ M 2 🛣 F Dec. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No MD Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21797 3265 Florence Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Faye Sells Arden C. Weygandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3265 Florence Road Woodbine, MD 21797 Faye R. Hodiak/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/05/12 Woodbine, MD Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 1481 Time disease or condition resulting in death) Month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a sonesquence of): ettending physician and for use as the burial-transit Hospital or Attending Physicien: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year erei Director: After this certificate has been signed by the e filled in by the funeral director, pege 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 ☐ Acciden 3 ☐ Suicide 5 Pending Work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funerei Direct
completely filled in by 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title q certifie 29c. License number ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete

M DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sair vvaliace v		1- For State Registrar		Certificate o		id Mental i	R	eg. No. 2012	35719
Physic Medical Exam							2. Date of Dea Month	Day Year	3. Time of Death 1445 hrs
		Carl Wallace Wyant  4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	4b. City, Town, or Location of Death			ath
		Carroll Hospital Center			Westminster Carroll				
Funeral Director		132-30-2276	Sex 7. Age (In ) X <sub>M</sub> 2 F 72	yrs. last birthday) Yr	If Under 1 Ye Months Da		_	th(MM/DD/YYYY) 9. I 17 1940 For	Birthplace (State or eign Country Y
any		Usual Residence of Decedent  10a. State							10d. Inside City Limits
	To Be Completed by Funera	MD Carro	11	Finks	burg				1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.		10e. Street and Number 2551 Baltimore I	Boulevard #77		10f. Zip Code 21048		1	0g. Citizen of What Co USA	ountry?
5-0036 led within 72 hours after death with the Maryland tygiene. wher than "matural", or items 23a or 28a-f she the Medical Examiner must be notified at once		11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decedent Ever Armed Forces? 1 X Yes 2 N ed If Yes, Give Year	,1957+ "	Yes, specify Cuba	n, Mexican, Puer	Specify Yes or No to Rican, etc.)	White, etc.	erican Indian, Black,
urs afte tural" traine		3 Widowed 4 Divorce  15. Decedent's Education (Specify	or Dates:		Yes 2 X No		f work done	Specify: W	
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami		Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life			home imp	
		17. Father's Name (First, Middle, La					ne (First, Middle, N	Maiden Surname)	
2121 Muld be fill Mental F marked c event, i		Franklin John 19a. Informant's Name/Relationship		19b Mailin	a Address (Stre		Wright	nber, City or Town, Sta	te Zin Code)
		Mrs. Cynthia M.						inksburg, N	
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental ant: If item 27 is marked or other traumatic event,		20a. Method of Disposition  1 Burial 2 X Cremation		0b. Place of Dispo crematory or o		emetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: Hite injury or other tr		4 Donation 5 Other Spec	ify:	11 Count	-			Sykesville	
		21. Signature of Funeral Service Lice Parge Hardy Service	bert	P.	0. Box 1	95 Sykes	sville, M		& Chapel
Physician /Medical		23a. Part I. Enter the disease, or con failure. List only one cause on	each line.	eath. Do not enter	the mode of dying	, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Death  Due to (or as a consequence of):							
	L	Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause  (Disease or injury that initiated Consequence)							
ansit		(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.							
60, ate be executed hysician and e burial - transit	Medical	UNPENDED	AMENDED						
3760, ficate be g physic sthe buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p		etal death 3	Ectopic pregr		23d. Date of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	Physician/ł	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at time of	of dooth	etal death 3 ther (Specify)	Ectopic pregr	iancy	Month	Day Year
D.O. Be that the de- red by the a detached fo	Phy	Part II. Other significant conditions	9OHKHOWH	ot resulting in the	underiving cause	given in Part I	23e. Did to	bacco use contribute t	o the cause of death?
i, <b>P.O.</b> ires that th signed by	d by								obably 4 🗹 Unknown
Vital Records, bysician: The law require this certificate has been si I director, page 2 should b	ompleted				- "		24a. Was a		autopsy findings available completion of cause of
Recc The lav cate ha	E						perform	med? death?	
Vital Rec ysician: The l his certificate l	BeC	25. Was case referred to medical examiner?	Hospital:			of Death (Check			
of Vi ing Physi After this	<u>2</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	✓ ER/Outpatient 28b. Time of		ry at Work?	ng Home 5 1	Residence 6 Oth	er:
ion ( tending eath. or: Af the fur	ţi	1 Natural 5 Pending 2 Accident Investiga		1400 hrs	1	Yes 2 V No	Subject drive vehicle accid		e involved in motor
Division  To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could no	ot be 28e. Place of Injury - A	At home, farm, stre	et, factory, office t	ouilding, etc.		treet and Number or R	ural Route Number, City
ospital hours unceral y filled		4 Homicide Route 140 at Sandymount Road, Woole							
To the Howithin 24 h	Medical	(Check only 1 Certifying Physician. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
F W S	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	OUME	29d. Date signed (M.	onth, Day, Year)
100/		Theoder 14:	Kind JA	und.	O.C.			November 3, 20	012
		Name and address of person who Theodore M. King, Jr., M			900 W Baltin	nore Street F	Baltimore M□	21223	
S	tate	31. Date filed (Month, Day, Year)	2. Registrar's Sign			-			
Regis		NOV 0 7 2012	& Sknewa A	nature for					

amend #8tale of Marciano / Bepartment of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:20 PM JUANITA WRIGHT-PRETLOW Wenter Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 11 more timore If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)1954 213-62-7822 Director 1 🗆 M 2 🗔 F 3-13-<del>1955</del> MARYLAND 57 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County filed within 72 hours after death with the Maryland Director 1

Yes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 2303 N. PULASKI ST. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CERT NURSING ASSISTANT **HEALTHCARE** Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o JOHNNIE T. WRIGHT MATTIE L. PONE should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 SHUNANE/SHURON-WASHINGTON(DAUGHTER) 3835 DERBY MANOR DR. BALTIMORE, MARYLAND 21215 permit. Page 1 and 2 Department of Healt Important: If item 2 any Injury or other i timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial /2 Crem on 3 Removal from State MT. ZION CEMETERY 11-9-2012 BALTIMORE, MARYLAND 4 🗌 Dona tion 5 🗆 O 21. Signature HIBNER 2. Name and Address of Facility REDD FUNERAL SERVICE MAHTIANOLS 1721-27 N. MONROE ST. BALTIMORE. MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shoot, or heart failure. List only one cause on each line. Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSVICE 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Vovember 2, 2012 00159059 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-08316 Patrick White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 0 | 2 | State of Maryland / Department of Health and Mental Hygiene

	1- For State Cell Registrar Cell	ertificate of Death	Reg. No.				
Physician Medical Examine			2. Date of Death  Month Day Year  November 3, 2012	3. Time of Death			
)	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c, County of Death				
Euparal	St. Joseph's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs.	Iast birthday) If Under 1 Year If Under 24Hrs.	Baltimore Cour				
Funeral Director	213-82-2971 1 M 2 F 48	Yrs. Wonths Days Hours Min.	12/05/1963 Foreign	MARYIAND (TAND			
, any	10a. State 10b. County 10c. Cit	y, Town or Location	Í	10d. Inside City Limits			
-f show	MD BALTIMORE	TOWSON		1 Yes 2 No			
y, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once To Re Commissed by Firnaral Director	10e. Street and Number 305 E. Joppa Road Apt. 1	701 21286	10g. Citizen of What Count	•			
er death wi	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	U.S. 13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F					
ours after antine	I or Dates:	16a. Decedent's Usual Occupation (Give kind of wo	ork done 16b. Kind of Business/Inc				
5-0036 led within 72 hours a Bygiene. other than "natura the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retire		1			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last)	BRICK LAYER 18. Mother's Name (	CONSTRU  First Middle Maiden Surname)	ction			
21215 uld be file Mental Hy marked o	Milus white, SR.  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru					
D 21 should and Me 7 is ma	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or Ru	Iral Route Number, City or Town, State, 2	Zip Code)			
e, MD I and 2 sho Health and item 27 is	DAVID LOF/AND/NEPhew 20a. Method of Disposition 20b	Place of Disposition (Name of cemetery, company or other place)	Date 20c. Location - City or To	own, State			
S 2 7 4	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place)	2 2012 BALTIMORE,	MARYLAND			
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	21 Signature of Funeral Service Licensee	CARME CEMETERY  22. Name and Address of Facility  4. U. PAOU 11.	BERRICK C. Joi	UES FIH.P.A.			
Physician	23a. Part I. Enter the disease, or complications that caused the deat	h. Do not enter the mode of dving, such as cardiac or	VE. BALTIMORE, M	Appro mate Interval			
/Medical.	failure. List only one cause on each line.  Immediate Cause (Final disease a Oxycodone Into		a	Between Onset and Death			
examiner	or condition resulting in death)  Due to (or as a consequence						
à	Sequentially list conditions, if any, leading to immediate b. Due to (for as a consequence	of):					
ed nsit <b>Examine</b> r	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence	of):		<u> </u>			
cuted und transit	I d						
760, Gate be executed g physician and the burial - transit	■ UNPENDED AMENDED 23a, pt.	II,27,28a-f,per me,g936					
18760, tificate bung physic as the bundled		gnancy  2 Fetal death 3 Ectopic pregnan	23d. Date of delivery cy Month Da	y Year			
by the attending probed for use as the Physician	4 Pregnant at time of d	eath 5 Other (Specify)					
ache tree		resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to th	e cause of death?			
Records, P.O. The law requires that the freate has been signed by, page 2 should be detack. Completed by F.	Cocaine Use		1 Yes 2 No 3 Probal	bly 4 🗹 Unknown			
cords, law requir has been s			autopsy prior to cor	psy findings available npletion of cause of			
Rec The liftcate h			performed? 1 ✓ Yes 2 No 1 ✓ Yes	2 No			
of Vital Recing Physician: The After this certificate Juneral director, page		26.Place of Death (Check or ER/Outpatient 3 DDA Other Nursing	Home 5 Residence 6 Other:				
ing Phy Jing Phy After th funeral con: To	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work? 2	8d. Describe how injury occurred				
Sion Mittendi death. cctor: by the fi	1 Natural 5 Pending Investigation fd 9-2-95	[1d 13:00 pm]	ınknown				
Division of Vital Records,  To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should?  Wedical Certification: To Be Completed.	3 Suicide 6 X Could not be determined (Specify) LO	nome, farm, street, factory, office building, etc.  2 2 2 2 2 3 3 4 4 5 5 7 7 8 7 8 7 8 8 8 8 8 8 8 8 8 8 8 8	8f. Location (Street, and Number or Rura or Town, State) 400 block (Saltimore, MD.	Route Number, City			
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
To To Com	and manner stated.  29b Signature and title of certifier	29c. License number	29d. Date signed (Month	n, Day, Year)			
	6 aun 1 1	O.C.M.E.	November 4, 2012				
	30. Name and address of person who completed cause of death (the	r 900 W. Baltimpre Street, Baltimpre, M	MD 21223				
State			ND 21223				
Registra		bares					
DHMH 17 Rev 1/2001		ORIGINAL	0	OME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19a-b per INF, 9934 12-7-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 05:49 AM Medical Willie 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital of Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. **Director** 1 🗆 M 2 💢 F 218-26-2531 Usual Residence of Decedent 25 27 80 NC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2910 Bowers Ave 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Domestic Social Security Adm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pattie Arrington John Dyer 19a. Informant's Name/Relationship (Type, Print)

Maggie R. Mallory-Sister 195 Mailing Address (Street and Number of Bural Route Number City of Town, State Zip Code)
5919 W. Oxford St. Philadelphia, PA, 19151
5412 Juliet Street, Springfield, VA 22151 Ounitcoe Lee-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Druid Ridge 11/5/2012 Pilesville, Md Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore, Md Ave, 23a. Pa. 1. Enter the disease, or complications that cau of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Shock disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physiclen: The law requires that the death certificate be executed After this certificate has been signed by the ettending physician and funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cauca(e) and manner at classes.
3 Certifying Nurse Practitioner: It this basis of my knowledge due to be cauca(e) and manner at classes. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number Kaller, RES -000 October 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of baltimore REET 31. Date filed (Month, Day, Year) State Registrar 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** 4c. County of Death ltimore Madison 213 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Country) WV (Month, Day, **Director** or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1ti more 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1400 E. Madison Ave. 2/205 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working ife. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ner's Name (First, Middle, Last) ane (First, Middle, Maid ross (puntry Blud 920 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service rile 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or healt failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and s the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? 3 Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Roouve Arm 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas e 2 s autopsy page performed' To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner' 3 No Other: ဂ္ 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5-Residence 6 Other (Specify) 27. Mannes of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) 1- Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Configure Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address ania la State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 November 1600 MICHELLE ANN WRIGHT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 841 GLENWOOD AVENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Director 218-76-6112 1 □ M 2 🗓 F 49 Yrs. JUNE 26 1963 MARYLAND Usual Residence of Deceder 10d. Inside City Limits ir then "naturel", or Items 23a or 28e-f sho the Wedlerl Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Meryland Director 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A. GLENWOOD AVENUE 841 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 Armo
If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: BLACK 3 Widowed 4 KNOivorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry perrit. Page 1 and 2 should be flied within 77 Det artment of Health end Mentel Hygiene. Importent: if item 27 is merked other then 'any injury or other traumatic event, it a Mer Elementary/Secondary (0-12) College (1-4 or 5+) ANN ARUNDEL CO COOK 12vrs Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JANNIEBELL WRIGHT ABRAHAM WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 GLENWOOD AVENUE, BALTIMORE, MARYLAND 21212 <u>Shawntia Stanton/Daughter</u> Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State HOLLY HILLS MEMORIAL 11-08-12 MIDDLE RIVER, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Seprice Licensee 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on pach line. such as cardiac or respiratory arrest Immediate Cause (Final ancot onn Physician/ 2/1/2, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physicien: The lew requires that the death certificate be executed
 24 hours after death.
 Funerei Director. After this certificate has been signed by the ettending physician and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physicien: The lew requires that the death certificate be exe within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician are completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 88760 Wichell Wright IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🎽 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🕱 Residence 6 Dother (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 0002790 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 0 7 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day WAJER 2 0 1 2 Physician/ MELVA Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore PARKWAY Perplug BALTIMORE Center Birthplace (State or Foreign Country) f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 95 217-12-8606 Maryland 1 □ M 2 T F Director Nov. 11, 1916 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director or 28a-f sl Abingdon Harford MD 1 Yes 2 X No 10g. Citizen of What Country? 10f. Zip Code Ь 10e. Street and Number pe ms 23a o must be 2911 Toddsbury Court 21009 United States "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates Specify: White 3 ☐Widowed 4 ☐ Divorced ed other than "natu event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) At Home Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked of other traumatic even Sophie Proitkowski Walter Stankowski 2 19a. Informant's Name/Relationship (Type, Paughter-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Wajer- in-law 2911 Toddsbury Court Abingdon, MD 21009 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot November St. Cemetery crematory ar other place)
Stanislaus
Cemetery 1 M Burial 2 Cremation 3 Removal from State Dundalk, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Evans Adminification Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 (3a. P nt). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest s lock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death mme diate Cause (Final isee e or condition re ting in death) DEMENTIA ALZHEIMER Physician/ Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death rate has been signed by the spage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò HYPERTENSION 1 ☐ Yes 2 ¥ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 🐕 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending 1 Natural injury 1 Tes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2012 R152171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095 Marshalee Dr. Elkridge, ENEC ANAPOlsiu 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Peyton Randolph Wise, II. Medical November 2012 1:38 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2 Wynchurst Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. Director 549-40-5557 1 🛛 M 2 🗆 F 81 October 05, 1931 Buffalo, New York or then "netural", or items 23a or 28e-f show 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Wyndhurst Avenue 21210 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 U.S. Navy Captain other traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentel F permit. Pege 1 end 2 should be fli. Depertment of Health and Mentel importent: If Item 27 is merked of eny injury or other traumetic eve John H. Wise Ethelwynne Frick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlas Wise (Spouse) Wyndhurst Avenue Baltimore, Maryland 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other places. Evans Funeral Chapel-Bell All 1 Burial 2 Cremation 3 Removal from State November 06, Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licer Name and Address of Facility Evans Funeral Chapel & Cremation Services-Monkton 16924 York Road Monkton, Maryland 21111 23a. Part 1. Enterithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Priysician Medical resulting in death) Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ever the cause of the cause (Disease or injury that initiated ever the cause (Disease or injury the cause (Disease or injury that initiated ever the cause (Disease or injury the cause (Disease or Examir or Attending Physicien: The law requires that the death certificete be executed ettending physiclan end I for use as the burlel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed I should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate hes funeral director, page 2 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 잍 1 Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5XXResidence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗆 Yes 2 🗆 No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number,

P.O. Box 68760 Records, Division of Vital

. 24 hours after death. e Funerei Director: Aft letely filled in by the fur Hospitei To the Hosp within 24 how To the Fune completely fi

> State Registrar

DHMH 17 Rev 06-2011

Medicai

29a, Certifier

(Check

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

teharty III Mp

cellle

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Baltimore

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20128:39AM Armold Eugene Wagner Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County Examiner 4b. City, Town, or Location of Death Upper Chesapeak Medical Center Rel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 74 Director 213-36-8533 1 M 2 D F Yrs Maryland July 16, 1938 and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f show aumetic event, the Medical Examinat must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Harford County Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21015 500 Plumbree Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status vvas Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Edbewood Arsenal Complex Chemical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Larve Sullivan Herschel Clayton Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is eny Injury or other trau 500 Plumbree Road, Bel Air, Maryland 21015 Diane Deloris Wagner (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Lutheran Cenetery 11/07/2012 Manchester, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 & COM November 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Lau Medical resulting in death) Due to (or as a consequence <sup>/</sup>Examiner Sequentially list conditions, if a y leading to in recliate cause. Enter Underlying Cause (Disease or injury that initiated events Sue to (or as a consequence of): Exami physiclan and s the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be use as ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month signed by the et Id be detached fo Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hes autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifical completely filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 npatient 2 ER/Outpatient 3 DOA ဂ္ Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier N. vember 2, 2012 D0053568 upper Chesapeake 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOMPSON cer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death November 3, Physician/ 2012 Donna Jean Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Street 3105 Adv Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 218-36-6619 1 □ M 2 🔀 F Apr. 8, 1941 Maryland 71 Usual Residence of Decedent 10a. State 10c. City, Town or Location at Director or 28a-f sl notified Harford Street Maryland + 23a o, 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral must k 21154 USA 3105 Ady Road death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ori þ 1 Never Married 2 X Married Yes, Give 2 🔀 No within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene.
Is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home 11 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeanette Virginia Butts Edward Joseph Langlais 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other tra Robert Wilson / Husband 3105 Adv Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Harford Memorial Gdn. Donation 5 DiOther (Specify) 11-7-12 Aberdeen, Maryland f Funer 22. Name and Address of Facility
McComas Funeral hatuk Home. 50 W. Broadway, Part 1. Enter the disease, or complications that caused the death. Lo not ent, the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to as a consequence of Examiner Sequentially list conditions, it any seeing to immediate cause. Enter Underlying Examiner Due to or as a consequence of that the death certificate be executed burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death the Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 4No 3 Probably 4 Unknown Records, or Attending Physician: The law requires Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 Yes 2 A Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of injury 28b. Time of 27, Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month) Day, Year) 29b. Signature and title M poson who completed cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

35728

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 X No

2:35 A M

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2012

. Registrar's Signa

12-08219						
Trov	Elliott	Winter				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Troy Elliott Winter	1- For State Registrar	State of Marylan	d / Department Certificate		nd Mental	R	eg. No. 2012	35729
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year							
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  19419 Battleridge Way  4c. County of Death  Montgomery Village  Montgomery					h		
Funeral Director	5. Social Security Number 217–82–9816		Age (In yrs. last birthday	) If Under 1 Ye	ear If Under 24	Hrs. 8. Date of Bi	rth (MM/DD/YYYY) 9. B	
·	Usual Residence of Deced	ent						10d. Inside City Limits
te Maryland nr 28a-f show any fied at once. Jirector	MD Mon	itgomery	10c. City, Town or Lo		<u> </u>			1 Yes 2 No
Marylan 28a-fs daton recto	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
rith the 123 nr rotifie	19419 Battle	eridge Way	ent Ever in LLS 13	20886 Was Decedent of F	lispanic Origin? (	Specify Yes or No	USA	rican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a nr 28a-f sho injury nr other traumatie event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2	Married Armed Force  1 Yes  Divorced If Yes, Give Year		If Yes, specify Cub	an, Mexican, Pue		White, etc.	
hours aft natural Examine ed by		l or Dates:	durir	edent's Usual Occup g most of working li			16b. Kind of Business	/Industry
5-0036 ed within 72 hour tylgiene. other than "natu the Medical Exau	Elementary/Secondary (	0-12) College (1-4		s Blower			Art	
21215-0036 Juld be filed within 7 I Mental Hygiene, marked other than its event, the Medica TO Be Comple	17. Father's Name (First, N Page Winter	liddle, Last)			Valeri	e Ashmead		
ID 21 2 should and Mee 27 is man martic ev	19a. Informant's Name/Relation L. Wint		19b. Ma   <b>19</b> 4	ailing Address (Str 19 Battle	eet and Number o	or Rural Route Nur	mber, City or Town, Stat	e, Zip Code) age, MD
Baltimore, MD semit. Pages I and 2 shc Department of Health and Important: If item 27 is njury nr nther traumati	20a. Method of Disposition	mation 3 Removal from		sposition (Name of or other place)	emetery,	Date	20c. Location - City o	r Town, State
it. Page rtment ortant:	4 Donation 5 Other Specify: Final Journey Crematory 11/05/12 Woodbine, MD  21. Spinature of Funeral Service Licensee Final Journey Crematory 11/05/12 Woodbine, MD  22. Name and Address of Facility  Ging Home Cremation Service P.O. Box 784							
1000	16 00	Helite se, or complications that caus	MO1251 ⊞	oing Home everly L	: CRemat: Heckrol	ion Servi tte, P.A.	ice P.O. B Clarksvil	le. MD 21029
Physician Medical	failure. List only one	cause on each line.					rest, shock, or heart	pproximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):							
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Civical and Indian India							
0,  be executed sistian and burial - transit  edical Examiner	(Disease or injury that initial events resulting in death)	aleu -	nsequence of):					
), be exect sician an urial - tr	x UNPENDED ☐ AMENDED 23a,pt.II,27,per me,g934 12-6-12 sm							
6876 certificate nding phy ise as the	FFEMALE:   236. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   2   Fetal death   3   Ectopic pregnancy   Month   Month   4   Pregnant at time of death   5   Other (Specify)   9   Unknown   236. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Month   Month   1   Ves   2   No   9   Unknown   9   Unknown   236. Date of death   Month   Month   2   Fetal death   3   Ectopic pregnancy   Month   M						23d. Date of delive Month	ry Day Year
s, P.O. Box  irres that the death irres that the death is signed by the atte dedetached for it								
rds, P requires the been signs hould be dealeted b	Chronic Al	coholism				1Ye		utopsy findings available
Vital Records, P.C. ysician: The law requires that his certificate has been signed director, page 2 should be det. o Be Completed by						1 Yes	rmed? death?	completion of cause of
Vital ysician: ysician: his certil director	25. Was case referred to mexaminer?	[Hospital: , ]	atient 2 ER/Outpa		ce of Death (Che Other A Nur		Residence 6 🗸 Othe	er: Scene
on of Viending Physicath.  or: After this he funeral dir	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury occurred							
Division o spital or Attending nours after death. nersa Director: Aft filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division  To the Hospital or Attent within 24 hours after death and the Funeral Director: completely filled in by the Medical Certificatif	29a. Certifier 1 Certify	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
A S S S S	29b. Signature and title of		1/1-		nse number		29d. Date signed (M	
	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
of years								
State Registrar		COLUMN TO THE PARTY OF THE PART	strar's Signature	ø:				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

John Robert Williams Sk. 12-08235 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death **Medical Examiner** 1131 hrs October 31, 2012 <u> John Robert Williams, Sr</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4204 Friar Field Run **Baltimore** 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Countril Maryland Director Months Days Hours 1 

M 2 

F 212-62-8831 52 Yrs 07/02/1960 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a nor 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 Friarfield Run 21213 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married White, etc. 2 X No Yes 3 Widowed 4 Divorced Yes, Give Yeer 1 Yes 2 No specify: White Specify. ò Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanic Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Carl Robert Williams Evelyn Nordt 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Williams / Sister 5929 Marluth Avenue, Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify. Chesapeake Crematory 11/7/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Medical Between Onset and Death Immediate Cause (Final disease a. Head Injuries complicating chronic alcohol abuse Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification 1 Natural Subject fell FOUND: Pending 1 Yes 2 V No 2 🗹 Accident Oct 31, 2012 1110 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4204 Friar Field Run, Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2012 30. Name and address of person who completed cause of beath (Item 23a) Assistant Medical Examiner Zabiullah Ali, M.D. 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Barke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Reg. No. Certificate of Death Registra Decedent's Name (First, Middle, Last) Date of Death 00 Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 3048 Sounding Drive Edgewood 8. Date of Birth (Month, Day, Year) 12/16/1955 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Country)
Pennsylvania Days Hours 1 □ M 2 🛚 F Director Luku 56 Yrs of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Edgewood MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21040 3048 Sounding Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes Give Specify Completed 3 - Widowed 4 - Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 end 2 should be flied within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other transmitted. Elementary/Secondary (0-12) College (1-4 or 5+) Unkn Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cleo Dean Levi James Pollum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 140 Romford Circle, West Chester, PA 19380 Cynthia Shuren / Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 11/2/2012 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore. MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlal-transit After this certificate has been signed by the attending physicien and it funeral director, page 2 should be deteched for use es the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops 2 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 No 4 🗆 Nursing Ho 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No м Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

NOV 0

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a 622 Per FH G933 11/07/2012 JH State of Maryland / Department of Health and Mental Hygiene 357 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28th 12:00 AM October 2012 Kathryn Woolridge /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Future Care Irvington Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 9, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 1 □ M 2 🗓 F Maryland 94 Director 213-20-4310 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f shov Examinar must be notified at 1√2 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 2364 Washington Blvd USA Pages 1 and 2 should be filed within 72 hours after death wnent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23s

Lry or other traumatic event, Its Medical Examinational Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) customer service rep Gas & electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be Richard Parks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Woolridge/grandson 2110 Harman Avenue Baltimore, MD 21230 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of IImportant: If ite
any injury or ot
once. Cremation Center of MD 11/5/2012 Hanover Maryland 22. Name and Address of Facility Charles L. Stevens Funeral Home 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anat Baltimore, Anatomy Board 655 W more, MD 21201 21230 Baltimore, MD 21201 21230 1

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1501 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FHLURE TCUTE **Physician** DAY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 □Yes 2 No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an autopsy performed 1 ☐ Yes 2 Æ No 1 □Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)006586 M.D

State Registrar 31. Date filed (Mo

NOOLRI 16E

HAMMONDS

FERRY

BD

BALTIMORE, MD 21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 6, 2012 Walter Veasel 2:10A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City 5025 Montgomery Road Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 11, 1925 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Director 212-20-3811 1 X M 2 - F 87 MD Usual Residence of Decedent or than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 TNo MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5025 Montgomery Road USA 21043 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 M Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 end 2 should be filed within 73 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Minister and Teacher Clergy / Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lulu Boyd William Edward Veasel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. H. Ilene Veasel 5025 Montgomery Road Ellicott City, MD 21043 (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Crest Lawn Mem. Gardens 11/10/12 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 M00764 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition years Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗵 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 TTENDING 16200 NOVEMBER 6, 2012 who completed cause of death (Item 23a) (Type, Print) 720-C MAIDEN CHOICE LA. BALTO. MD. 21228 ORBERTO MACHIRAN M.D

State Registrar 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ () 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 23=18PM Physician Octob Alexis Zaloudek 30 2017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 66 Yrs. Feb 1, Maryland 1946 218-44-2341 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Yes 2 No Directo Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 21061 **USA** 23a 7955 Elvaton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, Black, White, etc. 1 Yes 2 1 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ۶ م 3 Widowed 4 Divorced Completed tal Hygiene. d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Alexander Timm Gertrude Lockner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traconce. James J. Zaloudek Jr., Husband 7955 Elvaton Road Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 11/08/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home, P.A. Thomas 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** wound Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Calciphylaxis

Due to (or as a consequence of). use as the burial-transi or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 3 Tectopic pregnancy Month. in the past 12 months? Day Year 5 Other (specify) 2 No 9 Unknown P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð on of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tyes 2 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To Director: After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire 29a. Certifier (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 He 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

per challed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiena Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20i2 Zimmerman 10:03 AM october Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Mary land Medical Cente Baltimore N/A If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Months Hours (Month, Day Year) 577-78-7220 56 Director Washington DC Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No Maryland Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r Funeral 20744 United States 4201 F1am Street Department of Health and Mental Hygiene.
Important: If item 27 is marked other.
any injury or other. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Zimmerman Carrie Bell Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilly R. Bolden / Sister 4201 Flam St., Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State Metro Crematory Inc. 11/01/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) conchoesophageal Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law autopsy performed Yes 2 After this certificate has funeral director, page 2: 2 No 1 L Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending death. Investigation 2 🗆 No Accident 24 hours after death Funeral Director, completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Kcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29c. Ljcense number 29d. Date signed (Month, Day, Year)

State Registrar · Greene St. Baltimore, MD21201

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 351 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 3:35 P M October 2012 Albert Ziegler Harry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 12607 Layman Road Thurmont If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Jan. 27 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1936 1 **X** M 2 □ F Maryland 76 **Director** 214-34-2503 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f 1 🗌 Yes 2 🔀 No Maryland Frederick Thurmont 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò ms 23a or must be r Funeral U.S.A. 21788 12607 Layman Rd. "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 X Married 1 Yes 1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) school custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Stitely Clarence Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rocky Ridge, MD 21778 <u>Edna Wolfe/ daughter</u> 12621 Eaton Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State Creagerstown Cemetery 11/2/2012 4 Donation 5 Other (Specify) Creagerstown, MD 21. Significant for a structure 1. 22. Name and Address of Facility Hartzler Funeral Home, P.A. Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acre Myocardial Pttysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner with Implanted Definition Tuch Cardia Cause (Disease or iinjury that initiated events resulting in death) Last Ventricolar The law requires that the death certificate be executed -tran and Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) ☐ Pregnam
☐ Unknown sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Itypertensium. 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5  $\square$  Pending Investigation Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 29c. License number mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 63 Thomas Frederick, MD Gerard Del Grippu Jr. mo Johnson Dv. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Joseph Abbott Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT IOSEPH MEDICAL CENTER UWSOR BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Hours Days July 29, Year) 915 Marry land Director 212-09-8573 1 XM 2 □ F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 2300 Dulaney Valley Rd; Apt W207 21093 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force 1 ☐ Yes 2 🔯 No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Un (Specify only highe st grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Everett Brown Abbott Adele Marie Seltzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Brooke Talbot - granddaughter 6021 Ascending Moon Path; Clarksville, MD 21029 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature Funeral Survi 22. Name and Address of Facility State Anatomy Foard Licens 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Certificate: To 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) nna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2012

12-08237 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kwame Abban State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day October 31, 2012 0558 hrs **Medical Examiner** Kwame, Abban 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) **Ghana** Months Davs Hours Director 10/10/1951 217-57-7287 1 XM 2 F 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No or 28a-f show Lanham tem 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at once. Maryland Prince George's Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho
ilury or other transmitte event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 u.s.A. 9893 Good Luck Road. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. Armed Forces? White etc. 1 Never Married 2 XMarried African-American 2 X No Yes 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Security Officer 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John Abban Kate Quansah 19a. Informant's Name/Relationship (Type, Print ) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8003 Duck Pond Terrace, Manassas, Virginia 20111 Kohi Abban - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) X Burial 2 Cremation 3 Removal from State 12/01/2012 Silver Spring, MD Gate of Heaven Cem. Donation 5 Other Specify. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring,MD 20904 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: 2 PR/Outpatient 3 DOA 1 Yes 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Oct 31, 2012 Driver auto auto collision 1 Natural 0518 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Outer loop of I-495 at I-95 , Adelphi, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10 M

State Registrar

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

8

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

November 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 11/5/2012 Physician/ 1:30 PM William Austin, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5190 Perry Rd. Airy Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Min. **Director** 578-48-1109 1 🔀 M 2 🗆 F 75 6/20/1937 DC Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5190 Perry Rd. 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Insurance Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. William Austin, Sr. Edna Marie Redman other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Jean Austin/Wife 5190 Perry Rd., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/2012 Rockville, MD Parklawn Cemetery 21. Signature of Funeral Service Licensee 22 Burrier Outer Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ na231 ( Bricer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Liter Ordenying Cause (Disease or injury Due to (or as a consequence of) that initiated events physician ar is the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 9 Unknown Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to acco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 V Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed this certificate 1 ☐ Yes 2 🗹 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manny of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completely filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar 31. Date filed (Month

DHMH 17 Rev 06-2011

vesiminster ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295 SPURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (A) 6:25PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death \* 130WIE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 8/10/1920 South Carolina Director 578-30-3567 1 □ M 2XX F 92 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Bowie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3712 Excalibur Court #104 20716 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72, and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Home Health Care Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whittier Parker Carrie New 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a : If item 27 is Carol Coates - Niece 6702 Robinia Road; Camp Springs, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 & Department of F Important: If ite 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State injury or Lincoln Memorial Cem. 11/9/2012 Suitland, Maryland 21. Sign vuje of funeral Service Lice viee 22. Name and Address of Facility Freeman Funeral Services any 4594 Beech Road; Temple Hills, Maryland 20748 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Medical a disease or condition resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury Exami burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No Yes director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh, g933 11-14-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Bryant, Jr. Year ao(a 2230 No vembe Medical 4a. Facility Name (if not institution, give street and number)
Union Memorial Hospital 4c. County of Death **Examiner** 4b. City Town, or Location of Death Baltimore 7. Age (In yrs. last birthday) 57 Social Security Number **Funeral** 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Country) MD Months Hours 1 (Nonth 1 Day, Noar) 216-62-7367 **Director** 1**¥** M 2 □ F Yrs. 10-18-55 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-fs Examiner must be notified N/A Baltimore MD 1 X Yes 2 No 10f. Zip Code 21213 10e. Street and Number 10g. Citizen of What Country? 3037 Shannon Dr. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. African "natural", or ģ 1 Never Married 2 Married 2 X No Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Amer. 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Walter B. Carter Elementary/Secondary (0-12) College (1-4 or 5+) Associate Hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မ John Bryant, Sr. Jean Ross 19a. Informant's Name/Relationship (Type, Print)
Yvonne Bryant/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3037 Shannon Dr., Balt., MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cem. 11/17/12 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility  $Hari_P$ . 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 Signature of Funeral Service icensee Part 1. Intel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Anoxic Brain Injury disease or condition resulting in death) 6 days Medical Due to (or as a consequence of): **Examiner** Arrest days Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consquence of): burial-transit days Bacteremia MSSA attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as the k IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death signed by the ar 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law I hin 24 hours after death. the Funeral Director: After this certificate has b autopsy performed 2 No 1 🗌 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ganna Becker MD AT 2438946-120 November 6 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janna Becker, Meastar Union Memorial Hispital, 201 East University Parkway, Baltimore, Mayland, 21218 31. Date filed (Month, Day, Year) NOV 0 8 2012

DHMH 17 Rev 06-2011

State Registrar

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 20 ľ<sup>2</sup> 8:00 Αм John R. Bland III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville Dulaney Valley Assisted Living If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** oct 31, 1941 Mary land Director 219-38-1357 1 X M 2 D F 70 10c. City, Town or Location 10d. Inside City Limits at Director "natural", or items 23a or 28a-f sledical Examiner must be notified 1 Yes 2 No Cockeysville MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral USA 21030 10815 Powers Ave. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc 2 D No 1963-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced 1965 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) bedding salesperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Katharine Fox Richard Bland Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 Darlene Rd; Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Christopher Bland - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signature of time I Service 22. Name and Address of Facility State Anatomy Board 21201 655 W. Baltimore St; Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ EREBROVASCUL AR disease or condition resulting in death) Medical Examiner 881481 RIPHERAZ Esqueritially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Month Vear Day Pregnant at time of death signed by the at d be detached for 1 ☐ Yes ∠ ☐ g ☐ Unknown g 🗍 Linknown Part II her significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARKINSON'S TSE ASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 Yes 2 C 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury 28b. Time of nours after death.

neral Director; After the filled in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury work?
1 Yes 2 No 5 Pending 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hou

To the Fune

completely fi

ပ

State Registrar only on

DEKHEN D

29b. Signatur

and title of certifier

31. Date filed (Month, Day, Year)

38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NETURANGALE MI)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

590

705 DigiTh On SUITEG CONTHIZUM MM 21090

29c. Li¢ense number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #19a Per FH G933 11/13/2012 In State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Julian S. Brewer, Jr. 9:25 A Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville 709 Maiden Choice Ln. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 218-18-0738 Country Director 89 1 XM 2 F MD Sept.9,1923 Usual Residence of Dece 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or items 23a or 28a-fs miner must be notified Catonsville MD Baltimore 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21228 719 Maiden Choice Lane Apt. HR. filed within 72 hours after death "natural", or iterredical Examiner n 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Forces? 1XX Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement 12th Attorney other traumatic event, Be 17. Father's Name (First, Middle, Last) . Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Theresa A. Miller Julian S. Brewer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 719 Maiden Choice Ln. Apt. HR236, Catonsville, MD June M. Brewer/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Prk. Nov. 3,2012 Elkridge, Maryland Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ō permit. Page Department of Important: It any injury or 21. Signature of tur ral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. Taluna 328 Sulphur Spring RD., Arbutus, Maryland 21227 an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Alzheimer disease or condition resulting in death) disease  $\alpha$ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy Yes 2 N e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Brawer

DHMH 17 Rev 06-2011

711

32. Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Corporation Day, Year)

P8905.0

Maiden Choice Ln Cathonsville MD 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 13 2012 19:25 PM Mary Ruth Braitsch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 1820 Spence St; Apt 412 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday, Hours July 27 Year 1917 Maryland Director 212-01-6987 1 🗆 M 2 🗓 F 95 Usual Residence of Decedent important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21230 1820 Spence St; Apt 412 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔯 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: permit. Page 1 end 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: If item 27 Is marked other then "natural", If Yes, Give 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) cutter factory unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Dora Smardon Spano Elmer Wersten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122A Mellor Ave; Baltimore, MD 21228 Theresa Harp - niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Services 22. Name and Address of Facility State Anatomy Board , Director W. Baltimore St; Baltimore, MD 23a. Part 1. Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INFARCTION SCHEMIC OF disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy this certificate 2 🗌 No ☐ Yes 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မ ie Hospital or Attending Ph n 24 hours after death. ie Funeral Director: After th bletely filled in by the funeral 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBAS MD 6336 Q. CEDAR ANE OLUMBIA 31. Date filed (Month, Day, Year) State NOV 08 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year Medical Eleanor Brooks 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Nursing Home Baltimore Towson
1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Hours (Month, Day, Year) unk Director 215-09-2544 July Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director MD Baltimore Towson 1 Yes 2 No 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 615 Chestnut Avenue 21204 USA items ; permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner my once. unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?.

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pickersgill Nursing Home 615 Chestnut Avenue Towson. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State Signature of Funeral Se 22. Name and Address of Facility State Anatomy Board Baltimore, MD 2120 *X*irector 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ Deblet disease or condition Herall Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE , nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed, Yes 2 X certificate ha 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No. ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending death. within 24 hours after death

To the Funeral Director; A
completed filled in by the fi 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) corre

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

NOV 0 8 2012

05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Year 10120 AM 20/2 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4c. County of Death EIKto e.c re If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Director ed other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hyglene. al Hyglene. d other than "natural", or Items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myrtle K. Banks Earl E. McMillian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code lianne NOOM landiar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signat Ronald S. Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death oronar Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed **Director:** After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B B 26. Place of Death (Check only one) Other 2 - No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending work 1 Tyes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 322

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6:30 AM Delores Kay Brown 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Regional Hospital Laurel Laurei George's 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) unk Months Davs Hours Min Oct 23 Yer 961 **Director** 218-86-0894 50 1 M 2 XF Usual Residence of Decedent or 28a-f show 10b. Count must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 5221 6th St. 21225 USA death Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours after deat and Mental Hygiene.

is marked other than "natural", or iten raumatic event, the Medical Examiner r 11. Marital Status unk 14. Race - American Indian, Black White e 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify If Yes Give 3 Widowed 4 Divorced Completed Year or Dates unk 15. Decedent's Education 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Laurel Regional Hospital 7300 Van Dusen Rd; Laurel, MD 20707 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or or 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signal Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Stage Disease Onset and Death End disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of): resulting in death) Last nding physician use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Cother (specify) for in the past 12 months? Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 2 No 9 X Unknown P.O. detach þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 1 Yes 2 No Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 🗶 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \quad Yes 28b. Time of Certificate: 28d. Describe how injury occurred After X Natural 5 Pending injury death. within 24 hours after death.

To the Funeral Director: A completely filled in by the f Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 70093 20/2 7300 Van Dusen Roag ss of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital Gorantla 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BRADFORD Month 2:00 PM 10 2912 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE UTURE CARE HOMEWOOD NURSING, BALTIMORE MD JUME 8. Date of Birth If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Min. Nov 26, 1911 Maryland 215-22-0842
Usual Residence of Decedent **Director** 1 □ M 2 🗶 F 100 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** is 23a or zo.....ist be notified a 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 2700 N. Charles St. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. healthcare 4 nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Waters George Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 George St; Baltimore, MD 21201 19a. Informant's Name/Relationship (Type, Print) Raynette Noel - granddaughter 27 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 🔲 Burial 2 🔲 Cremation 3 🔲 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Servi 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ dionary disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to for as a consequence on attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 No Yes 2 No the Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 57543 1H4SICIAN

Registrar
DHMH 17 Rev 06-2011

State

REETINDER

NOV 0 8 2012

1940 W. BALTIMURE STREET BALTIMORE, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7:55 PM 2012 Carl Randolph Boles Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Baltimore Washington Medical Center Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) Days Hours Min. Director 219-26-2899 1 X M 2 □ F 74 Dec 26, 1937 Maryland Usual Residence of Decedent Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 ☐ No Jessup Anne Arundel 10e. Street and Number 10f. Zip Code Citizen of What Country? USA 20794 Funeral 7810 Clark Rd; Apt A49 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) security guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Georgia Graham Thomas Randolph Boles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Rd Apt A49; Jessup, MD 20794 Diane Boles - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of N 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signatur - Funeral Servi 655 W. Baltimore St; Ba timore, MD 21201 23a. Part 1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumania Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 📈 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R107529 October 25,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Dr Glen Burnie MD 21061 Howe ACNP-BC Kim 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2012 Registrar

DHMH 17 Rev 06-2011

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0405 AM Month 2012 DNA RUTH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CROSS SIL HOSPITAI MONTGOMERY SPRING NE Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Director 37-72-4992 1 □ M 2 🗹 65 31,194 Usual Residence of Decedent show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside Çity Limits Director 28a-f 1 Yes 2 □ No HYATTSVILL MD P.G. CO ems 23a or r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 7906 SULTER USW WAY items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 'natural", Specify: Completed 3 Widowed 4 Divorced BLACK 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 10th Security Wells Fargo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o 2 David Corbett Edna traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 HOLY CROSS HOSPITAL FOREST GLEN RD S.S. MD 1200 other. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover Harmony Mem Park 11-10-12 Signature of Funeral Service Licenses 22. Name and Address of Facility Terry A. Austin Fun. Wash. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ DIFFICILE LOSTRIBIUM COUT disease or condition « Medical resulting in death) Èxaminer STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami CIRR UER and that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical certificate be Box 68760 the attending | | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death the 9 Unknown Unknown P.O. | signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Munknown IPHERAL ARTERIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No I Director: A ed in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUPA 1500 FOREST GIEN RI 31. Date filed (Month, Day, Year)

State

Registrar

NOV 0

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pa Amend #1	rint in I	Black	Indelib VR G93	le Ink	Fns	ure A	II Copies Iental Hvo	Are L	.egible	
	-	For State Registrar					ertificate					Reg. No.	201	2 2575
Physicia Medic		1. Decedent's Name	ce	Block							2 Date of Dea	ath Ay	201	3. Time of Death
Examin	er			give street and number.  @ NORTHWES		PITA]			Location of				ounty of Dea	
Funeral Director		5. Social Security Nu 123-09-0	umber (		Age (In yrs. la	ast birthda	Months		If Under Hours		8. Date of Birtl (Month, Day			rthplace (State or Foreign ountry)
>		Usual Residence of		92 Yrs. 10c, City, Town or Location			07/03/	/1920		NY 10d. Inside City Limits				
farylane Ba-f sh tified a	ecto	-FL MD	10b. County Balt BROW	imore ARD	1		ELD BE	ACH	Ra1	Ltimo	re			1 ☐ Yes 2 🛣 No
with the Maryland s 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Nurr	nber 4204	Old Milfor	d Mil	1 Rd.						10g. Citize	n of What C	ountry?
eath wi	Fune	11. Marital Status	TH-OCEA	N-DRIVE- 12. Was Deceden		S. 1		441_ lent of Hi		21208 gin? (Spe	cify Yes or No- Rican, etc.)	<del>- 1</del>	. Race - Am	erican Indian,
ould le filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matke event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☒ Widowed 4 ☐ Divorced					1 Yes				nicari, etc.)	Sp	Black, Whi ec <i>ify:</i> WH	te, etc.  ITE
72 hour n "natu Nedical	Completed			t grade completed)		(G	ecedent's Usua ive kind of wor e. DO NOT use	k done d	ation <i>luring m</i> osi	t of worki	ng	16b. Kind	of Business	s/Industry
within /giene.	e Cor	Elementary/Secondary (0-12) College			r 5+)	line.		•	AKER				OWN	НОМЕ
e filed intal Hy ed oth	To Be	17. Father's Name (F	est)		SICHI	ET.			er's Name VNAH	e (First, Middle,	Maiden Sur		INOWN	
is a si		19a. Informant's Na	ame/Relationshi	p (Type, Print)		19b. M	lailing Address	•	and Numbe	er or Rura	l Route Number		wn, State, Z	(ip Code)
and Healt		LARRY B		N	20b. P		91 SOU'sposition (Nan		CEAN		E, DEER			H, FL 33441
nit. Page 1 ertment of ortant: If i injury or c		1 X Burial 2 € 4 Donation		3 ☐ Removal from Sta pecify)			crematory or o MORE HE				7/2012		•	STOWN, MD
permit. Page 1 and Department of I lump retant: If its any injury or of once.		21. Signature of Fur	neral Service Li	ensee	•						LEVINS			, INC.
		shock, or hear	rt failure. List on	com. It tions that caus ily one cause on each l		h. Do not	enter the mod	e of dying	g, such as	cardiac o	r respiratory arr		VIDE	Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (I disease or conditio resulting in death)		a. Due to (or a	ee B is a consequ	RA (	<u>_ /</u>	nn	om	bo_	CIC		_	Offset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):												
executed ian and urial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									1			
9 2 2	= 1			d										
certifica nding pl use as t	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcon			. П					23	d. Date of d	elivery
ne death / the atte ched for	Physician/Medica	in the past 12 r 1  Yes 2 9  Unknown	☐ No	4 Pregnan	t at time of c		3   Ectopic p 5  Other (sp		zy				Month	Day Year
s tha	by	Part II. Other signif	ficant condition	ns contributing to deatl	but not res	ulting in t	he underlying (	cause giv	en in Part	1.				to the cause of death?
aw requias been 2 shoul	Completed										24a. Was a	osy /	prior to	utopsy findings available completion of cause of
<b>sician:</b> The law r certificate has <b>t</b> director, page 2 s		25. Was case referre	ed to filedical					26 PI	ace of Dea	th (Check	1 🗆 Yes	rmed? 2 W No	death? 1 ☐ Ye	es 2 🗆 No
hysicia his cert al direct	To Be	25. Was cast referre examiner? De 1 1 V Yes 2	J No				atient 3 🗆 Do	Othe	er: 4 🗆 N		me 5 Resid	lence 6	Other Spe	tient hospice
Attending P death. ctor: After t yy the funer	icate:	27. Manner of Death 1 M Natural 2 Accident	h 5 ☐ Pending Investig			28b. Tim inju		8c. Injury work 1 🔲		. {	28d. Describe h	ow injury o	ccurred	
or Atte after des Director	Certificate:	3 🗌 Suicide 4 🗎 Homicide	6 Could n determin	ned 28e. Place of t	njury - At ho etc. <i>(Specif</i> y		, street, factory	, office			28f. Location (S City or Tow		lumber or R	ural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2	Medical Ex		f examination	n and/or in	vestigation, in	my opinic	on, death o	ccurred at	the time, date a	nd place, ar	nd due to the	e cause(s) and manner stated.
To the compl	Σ	only one) 3 29b. Signature and		Nurse Practitioner: To	the best of t	ny knowie	1		e number	ite and pie		29d. Date s	signed (Mon	th, Day, Year)
122		30. Name and addre	ess of person w	who completed cause o	death (Item	23a) (Tvr	De, Print)	> /.	58	10	3/	NOV	5	2012
)		31. Date filed (Mont	n B	03 69	139	Av	igh	-	Blu	80	rent	yre	7/18	06/
Stat Registra		NOV 0	8 2012	Seneral Services	strar's Signa	bar	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 ďľ Nathalie Phyladine Bolyard 2:14 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Commons Catonsville . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 X F Days 0972571925 West Virginia **Director** 236-40-9413 87 Usual Residence of Decedent 28a-f shov Director 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified 1 X Yes 2 No MD Baltimore n/a 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? /IS 23a 0, Funeral 1204 Sargeant Street 21223 United States items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", White Specify: 3 X Widowed 4 Divorced Completed er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the 8 <u>Bottle Inspector</u> Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Carmon Maier Bessie Lutishia Cool 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Mary Ann Bolyard / daughter 1204 Sargeant Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 11/06/2012 Zoc. Location - City or Town, State
Tunnelton, West Virginia cemetery, crematory or other place)
Mt. View United
Methodist Church Ce 1 Burial 2 Cremation 3 X Removal from State 4 - Ronation 5 - Other (Specify) Cemetery 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signat of Funeral Service Lam 2719 Hammonds Ferry Road Lansdowne, 0 MD 21227 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ R disease or condition Medical resulting in death) Due to (or as a consequence of) weeks **Examiner** Sequentially list conditions, if any, leading to immediate sause. Enter Onsenying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 5 Other (specify) Pregnant at time of death Day Year been signed by the s 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed certificate Yes 25. Wa e referred to medical examiner? 26. Place of Death (Check only one) director. Be Hospital Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b, Time of 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hc

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nivember &, 2012 29c. License number 12754 Kaya WID Ciletra

Registrar

State

31. Date filed (Month, Day, Year)

Suite 4H, Baltimera

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), GETHA RAJA MD, 4367 HOUM FORM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October 18, Physician/ 2012 Jermaine Cooper 8:31 AM Bryan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 29 Director 217-17-7145 Oct 8, 1983 Virginia Usual Residence of Decede ar than "neture!", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Prince George's Forestville MD1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 USA 7420 Marlboro Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 ☒ No δ 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify. Black. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 end 2 should be fill tment of Heelth and Mental tent: If item 27 is markad o မ Myra Cooper Kenneth L. Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 Goldsboro Drive Apt 12H Hampton, Myra G. Cooper - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dapertment of h Importent: If its eny injury or ot once, cemetery crematory or other place)
Creative Cremation
Resources 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-26-12 Hampton, VA Metropolitan Funeral Service Signatur Funeral Service Ligensee 22. Name and Address of Facility 5517 Vine Street Alexandria, VA 22310 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mybealden 40215 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Hospitel or Attending Physician: The lew requires that the death certificate be executed 24 hours efter death.

14 hours efter death.

15 Funerel Director: After this certificate hes been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transi burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fli 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02068207 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road Clinton, MD 31. Date filed (Month, Day, Year) NOV 0 8 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4:53 2012  $P^{M}$ October <u>Viris Wather Cromer II</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Laurel Parkview at Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Country) unk **Director** 212-38-3789 1 💢 M 2 🗆 F 74 Vrs Oct 9, 1938 Usual Residence of Decede 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9010 Briarcroft Lane #106 20708 USA unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give unk 72 hours after Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. Completed 3 Widowed 4 Divorced white Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk .52 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Office Velasquez/PG Police Dept Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state f Funeral Se ce Licer Name and Address of Facility State Anatomy Baltimore, MD Board 655 W. Baltimore Street 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>j</sub> sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Day Pregnant at time of death 2 No g Unknown Unknown P.O. signed by detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy this certificate has page 2 2 No Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Director: After 1-Natural 5 Pending М Investigation filled in by the Accident Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after within 24 hours a

To the Funeral II

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier ပ

Registrar

Date filed (Month, Day,

3001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of D 2. Date of Death Day 2012 Month Physician/ 7:15 P M Cicci REGINA October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice at Northwest Hospital Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Days (Month, Day, Year) Director 1 M 2 F 74 179-30-0422 Pennsylvania Feb 27, 1938 Usual Residence of Deceder vuld be filed within 72 hours and the Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21218 4000 N. Charles St #1403 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black White etc. 1 Never Married 2 ☐ Married ģ Maryland 21215-0036 White 1 ☐ Yes 2 💹 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) University Hospital speech pathologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clara Helen Volkar Should be file and Mental H is marked of Clara Helen Nick Cicci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health ar Important: If item 27 is 1355 Cardinal Dr; Pittsburgh, PA 15243 Raymond Cicci - brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Ucensee Ronal J.G. S. Wade 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG Physician/ Canler disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ig physician end as the burial-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate hes been signed by the attending physician end letely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Other: 4 | Nursing Home 5 | Residence 6 | Other Specify 1 ☐ Yes 2 ☐ No ဨ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRajapahleMP D0057465 11/1/12

State Registrar 2835 Smin AV 5203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAJAPAKSEMD

NOV 0 8 2012

31. Date filed (Month, Day, Year)

Baltomore MD

12-07576	01		ase Type o							egible	<b>.</b>	
Robert Michael	Clai	T- For State	State	of Maryland				d Mental F	lygiene		201	2 357
		Registrar  1. Decedent's Name	/First Middle Lest	,	Certific	ate of De	eatn		2. Date of De	Reg. No.	L 0	
Physici Medical Exam			Michael C						Month	Day	Year	3. Time of Death 1156 hrs
Mar. N. P.		4a. Facility Name (if			1	4b. C	ity Town or	Location of Deat	October		. County of Deat	
		Meritus Med					agerstown				Vashington	
Funeral		5. Social Security N	umberunk 6. Se	x 7. Ag	e (In yrs. last birt	hday) If	Under 1 Year	If Under 24Hr	s. 8. Date of B	Birth (MM/I	DD/YYYY) 9. Bir	thplace (State or unl
Director			讴	M 2 F	36	Yrs. M	onths Days	Hours Mi	Nov 24	'i 10	Forei	gn puntry)
<i>3</i>		Usual Residence of							FIOV Z	7, 10	,,,,	
'any		10a. State	10b. County		10c. City, Town	or Location			-			10d. Inside City Limits
vfaryland 28a-f show any 1 at once.	ō	MD	Washing	ton	Hag	erstown	n					1 Yes 2 No
Maryl 28a-1 d.st.o	Director	10e. Street and Num				10f.	Zip Code			_	zen of What Cou	ntry?
h the 23a or	Ö		Prospect	St.			21740			US	5A	
th wit	Funeral	11. Marital Status  1 Never Marrie		12. Was Decedent Armed Forces?				panic Origin? ( S , Mexican, Puert		lo-	<ol> <li>Race - Amer</li> <li>White, etc.</li> </ol>	ican Indian, Black,
er dea , or if	Ē	3 Widowed	4 Divorced		No	4 🗀 V	2K No				o ' l	
rs aft ural"	ģ			or Dates: ly highest grade cor	npleted) 16a			ion (Give kind of	work done		Specify: Whi	
2 hou	etec	Elementary/Secon		College (1-4 or				DO NOT use re				
036 Ithin 7 Ine.	Completed	un	k	unk						1		
5-0 led wi other the M		17. Father's Name (	First, Middle, Last)	unk			1	18.Mother's Nam	e (First, Middle,	Maiden 9	Surname) unk	
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  ten 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at once.	Be											
D 2 should and M.	P	19a, Informant's Nar	, , ,	pe, Print)	198			and Number of			-	
e, MD 1 and 2 sho Health and Fitem 27 is		O.C.M.E			20h Place o	900 W of Disposition (		imore St	Date Date		.ccation - City or	
Ore ges 1 a of He If its				Removal from St		ory or other pl		ilicitery,	Date	200. 1.	.osation - City of	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5	Other Soecify:	ix/state		T				<u></u>		
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus		21. Signature of ! un	onald Service Licens	Wade, Di	rector			of Facility Sta 1timore		_		21201
Physician	-	2La, Part   Enter the										Approximate Interval
/Medical		failure. List only	y one cause on eac	ch line.			1			,		Between Onset and Death
Examiner		Immediate Cause (F or condition resulting		Acute Bro		шопта		•				
Marie .		Sequentially list con	ditions. b									
>	niner	if any, leading to imr	mediate D	ue to (or as a conse	equence of);							
	g	(Disease or injury the	at initiated C	ue to (or as a conse	equence of):							
executed an and al - transit	Exa		d									
ਂ ਲੋਕ	dical	X UNPENDED		AMENDED 23a	pt.II,2	7,per	me,g93	34 12 <del>-</del> 19	-12 sm			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician: completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Med	IF FEMALE: 23b. Was decedent p	regnant in the	23c. If yes, outcor	ne of pregnancy					1	Date of deliver	
OX 687 eath certific attending I	cian	past 12 months?		1 Live birth  Pregnant at	time of death 5		_	Ectopic pregn	ancy	'	Month [	Day Year
Box e death the atte	ysic	1 Yes 2 No	o 9 Unknown	9 Unknown	٥	Other (	Specify)					
that the d ned by the detached		Part II. Other signifi	cant conditions	contributing to death	n but not resulting	in the underl	ying cause gi	iven in Part I.	23e. Did t	tobacco u	ise contribute to	the cause of death?
ires that signed I be deta	Completed by	Chronic	Obstruct	ive Pulm	onary Di	sease			1 Ye	es 2	No 3 Prot	pably 4 🗹 Unknown
ords w requir	lete								24a. Was auto			topsy findings available completion of cause of
Reco The law icate has	틹					-				ormed?	death?	
tal Rection: The certificate ector, page		25. Was case referre	ed to medical	4 25 1			26.Place	of Death (Check		2110		2 110
Vital   ysician: this certifi director,	o Be	examiner? 1 ✓ Yes 2	No Ho	ospital: 1 Inpatie	nt 2 🗹 ER/Ou	tpatient 3	DOA	Other Nursi	ng Home 5	Residen	nce 6 Other	:
Division of Vital Records, rad or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	=	27. Manner of Death		28a. Date of Inju (Month, Day,Y	ry 28b. 7	ime of Injury	28c. Injury	y at Work?	28d. Describe	how injur	ry occurred	
Sion Attendi death. xtor: A	읥	1 X Natural 2 Accident	5 Pending Investigation				1 Y	es 2 No				
Division ppital or Attenciours after death leral Director:	)	=	6 Could not b	28e Place of In	jury - At home, fa	rm, street, fac	tory, office bu	uilding, etc.	28f, Location ( or Town,		nd Number or Ru	ral Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	4 Homicide	determined	(Specify)		_						
To the Hos within 24 h To the Fu	_	1-11-11-11-1		n: To the best of my								
To th within To th	Medical	29b. Signature and ti		and manner stated.	impacion and/or ir				at the time, date			
		ZOD. GIGHALUFE AND U			_//	100	29c. License O.C.M			1.	ate signed <i>(Moi</i> ber 7, 2012	ки, рау, төаг)
		1-1/14			1/0	1/1	U.U.IV	//. L.		1000		
		30. Name and address Russell Alexa		ompleted cause of d Assistant Medic		900 W F	Baltimore S	Street, Baltin	nore, MD 21	1223		
6		31. Date filed (Month			's Signature	- 4/		- 1.03t, Daitill				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 22, 201<sup>Y2a</sup> 10:45 Kathy Lynn Channick Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casev House Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Feb 6, 1951 Pennsylvania Director 211-38-8108 1 □ M 2 🗓 F Usual Residence of Decedent or than "natural", or Items 23a or 28a-f shorth M. Coal Eveniner is ust be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 **IISA** 10410 Burnt Ember Dr. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiana. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) education educator Be permit. Page 1 and 2 should be filed Dapartmant of Haalth and Mental Hy Important: If Item 27 Is marked ott any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Slogoff Stanley Channick 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10410 Burnt Ember Dr; Silver Spring, MD 20903 Michael Kanze - husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Licen Licen Signature of Euneral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death cartificate be executed burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last igned by the attanding physician ba datached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown paga 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 🗆 No within 24 hours aftar daath.

To the Funeral Director: After this certifics complately filled in by the funaral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caus

State Registrar 31. Date filed (Month, Day, Year)

NOV 08

Registrar's Signature

400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 4C, 28E-F, PER MD 6933 11/8/12 TRT
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician **Physici** RUTH COLEMAN 15 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PARKVILLE MORNINGSIDE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2**/**F South Carolina 237-16-672 6/18/1920 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number J-SA 21234 HARFORD 8800 Funeral 14. Race - American Indian, Black White, tc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Checker Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Rebecca Duffy James B Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 DIGITAL Department of Health a Important: If item 27 is any injury or other tra once. 21090 DR, LINTHICUM PRIMARY CARE PROVIDER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2012 Metro Crematory Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wierefeld Funeral Home Inc ignature of Fun r 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the digease, or confilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dement a /Medical Due to (or as a consequence of): 7507VS **Examiner** HIO CVA HIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):  $\neq \mathcal{A}(\mathcal{L},\mathcal{A})$ e  $\rightarrow \mathcal{L}$ Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown HOC VA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HTN performed? DEMENTIA 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident af er death Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R170382 17/12 D. Well, Ur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. WERE 705 DIGITAL DR ST9, LINTHICUM ZIO90 DOROTHY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 250 AM Carrier 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Keed Nash 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours 82 023-26-2621 1 🖾 M 2 🗆 F New Jersey July 13, 1930 Usual Residence of Decede 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Myersville Frederick 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21773 1880 Monument Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 1954If Yes, Give Year or Dates. 1958 Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)

mechanical

18. Mother's Name (First, Middle, Maiden Surname)

Mary Doris Winans

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1880 Monument Rd; Myersville, MD 21773

engineer

or 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev

Physician/

Medical

**Examiner** 

**Funeral** 

Director

For State Registrar

0a. State

MD

12

17. Father's Name (First, Middle, Last)

Earl Gardner Carrier

Janet Carrier Ady - daughter

19a. Informant's Name/Relationship (Type, Print)

Director

Funeral

Completed by

Be

မ

Physician. Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis

P.O. Box 68760

Division of Vital Records,

	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from		e of Disposition (Nametery, crematory or o	me of other place)	Date	20c	20c. Location - City or Town, State					
	4 X Donation 5 Other (Specify)											
	21. Sign ture a Funeral Service Licepse Rental	Director		M. Balt:			ny Board .more, MD	21201				
Completed by Physician/Medical Examiner	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):											
ıysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   1											
ted by Pr	Part II. Other significant conditions contributing to		, -	_	ırt I.		ute to the cause of death?					
Somple	J1					24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?					
Be (	25. Was case referred to medical examiner?			26. Place of De	eath (Check onl)	y one)						
2	Hospital:	☐ Inpatient 2 ☐ ER	VOutpatient 3 🗀 D	OA Other: 4	Nursing Home	5 Residence	6 Other (Spec	ify)				
ficate:	1 Natural 5 ☐ Pending (M 2 ☐ AccidentInvestigation	te of injury 28 onth, Day, Year)	Bb. Time of ginjury M	28c. Injury at work? 1 \square Yes 2	28d.	Describe how in						
Certi		ce of Injury - At home Iding, etc. <i>(Specify)</i>	e, farm, street, factor	y, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical Certificate:	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Ch	asis of examination ar	nd/or investigation, in	my opinion, death	occurred at the t	time, date and pla	ace, and due to the	cause(s) and manner stated.				
_	29b. Signature and title of certifier		290	c. License number	r	29d.	Date signed (Month	n, Day, Year)				
	Mars m.mo	0000	R093556 10/23/12									

State

Registrar

30. Name and address of person

NOVO8

1126

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catalano 2012 8:45 A Nov. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Country) Director 082-12-0273 1 □ M 2√□ F 90 Dec. 28 1921 NY Yrs Usual Residence of Decede or than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Lehigh Acres FL Lee ٥ 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 10500 Newbury Ct., S.E. 33936 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Puerto Rican Specify: Puerto Rican Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba fila h and Mantel F 7 is merked of ၉ Juan S. Reyes Elsie Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 sl of Health a item 27 li 36 Culmore Ct., Timonium, MD 21093 Nohemi Cecil/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1 Depertment of Important: If it ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/6/12 Glen Burnie, MD 21. Signature of Fineral Service Licensee 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, Inc. 0 W. Padonia Rd., TImonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attanding physician end for usa es tha burlai-trensit The law requires thet the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day ad by the a detachad f 9 Unknown P.0 Part II. Other significant conditions contributing/to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signad d be de 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 Aftar this cartificete funarel director, pag 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: Within 24 hours after death.

To the Funerel Director: Aftar this cartiflocomplataly fillad in by the funarel director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 D Other (Specify) NO SOLU 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) WO 6701

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ching Veda Pauline November 05 20**1**2 12:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Multi Medical Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 235-38-5596 Director 1 M 2 XF 91 Yrs. 1920 Dec. 04, West Virginia 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD. n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 447 Whitridge Ave. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oafta Aloa Allen Willie Arthur Godwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Spencer/ Daughter 8619 Wilenoak Court Baltimore, MD. 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Cemetery Marriottsville, MD. 11-10-12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice <sup>22. Name and Address of Facility</sup>
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 23a. Part 1. Bitter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THEROSCUPTOTIC CAMPION AS EUGAR DICEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Petal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours are now....

To the Funeral Director: After this certifical of the Funeral director, f 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifié Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. orly one) 29b. Signature and title of certifier 120080280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Stamus Run H> # E, ESSER, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 8:35 Рм Bernard Jackson Conroy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Dav. Year) Months 438-20-8327 Director 1 ፟M 2 □ F Yrs. 1927 3. Louisiana Feb. Usual Residence of Deced or then "naturel", or items 23a or 28a-f show the Wedical Evaniner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🂢 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit, Page 1 and 2 should be filed within 72 hours after death with I Department of Health end Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a eny Injury or other treumatic event. Funeral **USA** 21286 1132 Gypsy Lane West 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Completed white rear or Dates. 1944-1978 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) United States Army 5+ Colonel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 2012 Mary Dyer Bernard John Conroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1132 Gypsy Lane West; Towson, Joan M. Conroy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20c. Location - City or Town, State NOVEMBER 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Arlington, VA 1050 York Road 21. Signature of Funeral Service Viceospe 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) <sup>'</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam sician and burial-tran Due to (or as a consequence of): resulting in death) Last ettending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy BERNARD CONROY in the past 12 months? 5 Other (specify) Month Day signed by the et I be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed pege 2 should be de 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Yes 2 X No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 MORGAN, 31 Date filed (Month State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ Doualas Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death Southern Prince Georges Maryland linton Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Days Min. (Month, Day, 240-40-1759 Director 1 🗆 M 2 💢 F 80 23-03-J. Hygiene. Jother then "netural", or Items 23e or 28e-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location flied within 72 hours after death with tha Maryland 10d. Inside City Limits Director Prince Georges DUITLAND 1 🗆 Yes 2 🗷 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 Glenn 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ፩ altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) DC Government School it. Page 1 and 2 should be filed with threat of Health and Mental Hygler rtent: if Item 27 is marked other in plury or other treumatic event, the 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barnette Blanche Kesler HOKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3431 Glenn Drive Suitland, MD 20746 unda Hnn Douglas, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If I eny Injury or o 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Beltsville, MD Chesapeake Crematory 10/30/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Fundamental 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Rd Temple Hills, MD 20748 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure: List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): anding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physicien: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ₫ in the past 12 months? Month 5 Other (specify) signed by the a id be detached f 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Programmers within 24 houre after death.

To the Funeral Director: After this certificate? completely filled in by the funaral director, pag 1 🗌 Yes of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 I DOA မ Certificate: 27. Manner of Duath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) D068695 who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Rd Clinton, MD. 20735 Oyedele M.D. 31. Date filed (Month, Day, Year) Registrar's Signatur State 8 2012 NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month D November Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annandis Anne 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months (Month, Day, Year 224-68-203 **Director** Washington, OC Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Annapolis 1 🗆 Yes 2 🗹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 1200 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) POST OFFICE Clevic 12 1 and 2 should be filed wit f Health and Mental Hygiei item 27 is marked other i 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Deskins Carrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/40/ 19a. Informant's Name/Relationship (Type, Print) 1200 Cedar Park Road Annapolis permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Carrie MCPherson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Second Baptist Ch com. 11-10-12 Falls Church Ng, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ChiNN Funeral Service 21. Signature of Funeral Service Licensee Robert 2605 So Shirlington Rd. ARL. Van 2220-6 23a. Part 1. Enter the disease, or complications that caus • the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to ke as a consequence of buriel-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (anals a consequence of): Physician/Medical use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Por in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No of Vital To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death one mid at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0056336 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ma 10 V 888 Best gate Rd Ste 102 lam 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

NOV08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Doris Elaine Davies 4:50 A. October Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 709 Maiden Choice Lane S331 Catonsville If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) **Director** 1 □ M 2 💢 F 213-50-7479 96 May 14, 1916 Maryland Usual Residence of Decedent 28a-f show 10a. State the Maryland at 10c. City. Town or Location 10d Inside City Limits Director notified 1 Yes 2 X No MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 'natural", or items 23a o dical Examiner must be Funeral 709 Maiden Choice Lane S331 21228 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. White þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Johanna Ford Francis William Pramschufer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Oliver Davies 2110 Plymouth Dr. N., Irving, Texas 75061 Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Parkwood Cemetery 11/6/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility terling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funda Service Licensee 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ear. Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Tes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending work? 2 \ No Accident Investigation hin 24 hours after death the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

DHMH 17 Rev 06-2011

State Registrat

within To the

Medical

29a. Certifier

(Check only one)

ess of person who completed cause of death (Item 23a) (Type, Print)

arbenter

MD

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D30989

29d. Date signed (Month, Day, Year)

Maiden Choice Ln Catonsville MD 21228

notober 28 2017

29c. License number

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 430 OM Baby Boy Dutton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death In Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 2<sup>M2</sup>n Oct 17, Year 2012 Mary land Director INFANT 1 □XM 2 □ F Usual Residence of Decede item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20745 7305 Roanne Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important if item 27 is marked other than "na any injury or other traumatic event the page." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-1) INFANT INFANT Be 18. Mother's Name (First, Middle, Maiden Surname)
Tressa Dutton 17. Father's Name (First, Middle, Last) ೭ Marcus Kingsberry 19a. Informant's Name/Relationship (Type, Print)
Tressa Dutton - mother 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Toymy, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Signature of Funeral Service licenses 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician of previable disease or condition resulting in death) Delivery Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown page 2 should be detached for 5 Other (specify) Month Day Year Pregnant at time of death a 🗀 Unknown 10 2012 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 1 ☐ Yes → No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No death. Investigation 24 hours after deat Funeral Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 25-000 MD. MIH ess of person who completed cause of death (Item 23a) (Type, Print) Sangini 31. Date filed (Month, Ds), Year) Sheth Bell timore Orleans

State Registrar

NOV 0 8

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bobby Ray Doran October 1:55 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 4 Sycamore Street Hagerstown If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 214-48-2777 1 🛛 M 2 🗆 F 67 Yrs. 1945 Feb 21, Maryland 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🗓 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 21740 10g. Citizen of What Country? Funeral 4 Sycamore St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 🗌 Widowed 4 🔀 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 heavy equipment operator construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert William Doran Tempie Lynn Stottler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 'Zip Code) Brenda Doran - daughter 453 Clarendon Ave; Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Pat. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Due to (or as a consequence of): Cancer 4000 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Yes 2 No ed by the a 1 ☐ Yes 2 L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Comes 31. Date filed (Month, Day, Year) State NOV 08

Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:57PM NOVEMBER 2012 ANTOINETTE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth O Month, Day, Year) 9. Birthplace (State or Foreign If Under 24 Hrs. Hours Min. If Under 1 Year\_\_ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1 M 2 Y F 68 212-46-9457 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County at 1 ☐ Yes 2 ☑ No Director Dundalk Examiner must be notified Raltimore Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number United States 21222 1307 Delvale Avenue Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify: White ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15 Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Stella Blaszak Frank Malikowski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1307 Delvale Avenue Dundalk, Maryland 21222 Department of Health a Important: If item 27 is any injury or other tra Karol Dewald / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Holy Rosary Cemetery 11/08/2012 Dundalk, Maryland 22. Name and Address of Facility David J. Weber Funeral Homes PA Signature of Funeral Service 401 S. Chester STreet Baltimore, Maryland 21231 /en 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) POSTPARTUM ARDIOMY OPATH **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Эне to (or as a полаводывлен of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has perform 1 🗌 Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 npatient 1 🗌 Yes 2X No မ this funeral ( 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: Injury After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Could not be determined 4 - Homicide within 24 hours after
To the Funeral Directory completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 NOVEMBER 3, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 RUVU AVAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month I I Celia Davila 2012 7:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours Director 092-10-7092 96 1 M 2 X F 4/11/1916 Puerto Rico shov 10b. County 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Maiden Choice Ln. Apt SG321 21228 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Puerto Rican Hispanic If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiener Important: If item 27 is marked other the any injury or other traumatic event, the once. Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Mendoza Felipa Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maribel Franey 8510 Timber Pine Ct., Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 11/8/2012 4 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home Signature of Fineral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ erebrovosaler accident disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown g Unknown P.O. | signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Director: After this d in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

\*\*Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Butterworth CRNP

R082382

709 Maidenchi w Lane Cotonsville, Md 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (i) not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Northwest Hospital Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 220-54-7248 1 1 M 2 □ F 64 Usual Residence of Decedent Maryland 28a-f shov 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other treumatic event, the Medical Evanduar must be not lifted at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director 1 Yes 2 No Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21222 8017 Shore Road 12. Was Decedent Ever in U.S. Armed Forces?

1 IX Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced **'**68-73 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 end 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic events. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 auto tech automotive repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory O. Eck Doris May Rehberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Eck/spouse 8017 Shore Road Dundalk, MD 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Ser Ronal 22. Name and Address of Facility State Anatomy Bo Baltimore, MD 2 Board 655 W. Baltimore Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): ng physician and as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 🗌 Yes 3 Probably 4 D Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 4 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No MOSPILL မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manna of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t ■ Natural 5 Pending injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier pe, Print)

State

Registrar

31. Date filed (Month, Day, Year)

**NOV** 0

8

Physicia: Medic Examine Funeral **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

•	1 - For State Registrar			Certi	ficate of Dea	aur		Reg. No.	< U	1 6-	3577
	1. Decedent's Name (First, Middle,	Last)					2. Date of De			, ]	3. Time of Death
ı/ il	Elena I	Elkinova					Nov.	Day	2012	rear 2	12 P <sup>M</sup>
r	4a. Facility Name (if not institution,	give street and number)		4	1b. City, Town, or Loc				County of		
	3306 Paper Mil.  5. Social Security Number		+ // t t- i	(feedow)	Phoeni:	X Under 24 Hrs.	Lan. (D)		Balt:		
	N/A	1 0 14 2 0 5	e (In yrs. last birt <b>91</b>			lours Min.	8. Date of Bir (Month, Da Aug. 1	y, Yea <i>r)</i> 8 192	0.1	Country	
	Usual Residence of Decedent						TAUE. I	0 194	<u> </u>	Bulga	ria
CTO	10a. State 10b. County		10c. City, Town		tion					100	d. Inside City Limits
<u>lr</u>	MD Baltin	nore	Phoe	nix	107 71 0						1 🗆 Yes 2 💢 No
<u>e</u>	3306 Paper Mill	Road		- 4	10f. Zip Code	1134	1		izen of Wh <b>lgari</b>		y?
nue	11. Marital Status	14. Race -		Indian							
Be Completed by Funeral Director	1 Never Married 2 Marrie		No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.  1 ☐ Yes 2 ▼No Specify: White							
ted	3 XWidowed 4 Divorced	If Yes, Give Year or Dates.		1 _	LiYes 2.L <b>X</b> No S <sub>i</sub> ———-	pecify:			Specify:	whit	e
ple	15. Decedent (Specify only highes		16a.	(Give kind	nt's Usual Occupation of of work done during		ing	16b. Kir	nd of Busi	ness Indu	stry
5	Elementary/Seconday (0-12)	College (1-4 or 5 N/A	5+)	Che i	NOT use retired) F				F	ood	
Re	17. Father's Name (First, Middle, La	<del>'</del>		50		. Mother's Nam	ne (First, Middle,	Maiden S	-		
0	Rangel Garnevsk	i				Gina	Terziis		,		
	19a. Informant's Name/Relationshi	(Type, Print)	19b	. Mailing	Address (Street and I	Number or Rur	al Route Numbe	r, City or	Town, Stat	te, Zip Co	de)
	Lubomir Todorov	/son			Paper Mill	l Rd.,	Phoenix	, MD	2113	4	_
	20a. Method of Disposition 1   Burial 2   Cremation 3	3 ☐ Removal from State	20b. Place o		ion (Name of tory or other place)	Nove	Date mber 7,	20c. Lo	cation - Ci	ity or Tow	n, State
	4 Donation 5 Other (Sp	ecify)	Atlantic Crematory 2012 Glen Burn								
j	21. Signature of Free a Service UC	Blagle		22. N	Lemmon Full W. Padon:	recility neral F	lome of.	Dula	ney \	√a11e	y, Inc.
	I IIIICIIAEL X						rnomi	11m .	MID Z	1114 3	
		-	the death. Do r								
	23a. Part 1. En er the disease, or c shock, or heart failure. List on Immediate Cause (Final	omplications that caused ly one cause on each line	Э.	not enter ti	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between Onset and Death
	23a. Part 1. En er the disease, or c shock, or heart failure. List on	omplications that caused ly one cause on each line a, Adult Fa	Э.	ot enter to	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
	23a. Part 1. En er the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	omplications that caused ly one cause on each line a, Adult Fa	ailure t	ot enter to	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
iner	23a. Part 1. En er the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	omplications that caused by one cause on each line  a. Adult Fa  Due to (or as a	ailure t	of the control of the	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
Xammer	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	a. Adult Fa Due to (or as a	ailure t a consequence of a consequence of	of):	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
	23a. Part 1. Enter the disease, or can shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inipury)	a. Adult Fa Due to (or as a	e. ailure t a consequence d	of):	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	a. Adult Fa Due to (or as a	ailure t a consequence of a consequence of	of):	he mode of dying, su	uch as cardiac	or respiratory an			A	Approximate nterval Between
	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:	omplications that caused by one cause on each line  a. Adult Fa  Due to (or as a b).  C. Due to (or as a d).  Due to (or as a d).	a consequence of a consequence of a consequence of a consequence of pregnancy	not enter the control enter th	he mode of dying, su	uch as cardiac	or respiratory an	rest,		e li	Approximate nterval Between Onset and Death
	23a. Part 1. En er the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	omplications that caused by one cause on each line  a. Adult Fa  Due to (or as a b).  Due to (or as a d).  C. Due to (or as a d).  23c. If yes, outcome 1	aconsequence of a consequence of a consequence of a consequence of a consequence of pregnancy	not enter the co The off:	he mode of dying, su	uch as cardiac	or respiratory an	rest,	23d. Date o Month	A li	Approximate nterval Between Onset and Death
nysician/Medical Examiner	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter thinderlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 50 No 9 Unknown	omplications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).	a consequence of a consequence of a consequence of pregnancy 2  Fetal death it time of death	onto enter the control enter t	rive  ctopic pregnancy  ther (specify)	code 7	or respiratory an	rest,	23d. Date c	A li	Approximate nterval Between Onset and Death
	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unidealitying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 50 No 9 Unknown  Part II. Other significant condition	complications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	a consequence of a consequence of a consequence of pregnancy 2  Fetal death it time of death	onto enter the control enter t	rive  ctopic pregnancy  ther (specify)	code 7	7837	pest,	23d. Date o Month	of delivery	Approximate nterval Between Donset and Death Donset and Death Deat
	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter thinderlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 50 No 9 Unknown	complications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	a consequence of a consequence of a consequence of pregnancy 2  Fetal death it time of death	onto enter the control enter t	rive  ctopic pregnancy  ther (specify)	code 7	7837	pest,	23d. Date o Month	of delivery	Approximate Interval Between Donset and Death  Year
	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unidealitying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 50 No 9 Unknown  Part II. Other significant condition	complications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	a consequence of a consequence of a consequence of pregnancy 2  Fetal death it time of death	onto enter the control enter t	rive  ctopic pregnancy  ther (specify)	code 7	23e. Did to	obacco us Yes 2 <b>X</b>	23d. Date of Month see contribu	of delivery	Approximate nterval Between Donset and Death Donset and Death Deat
completed by Filysician Medical	23a. Part 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   7   No   9   Unknown  Part II. Other significant condition  Hypertension	complications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	a consequence of a consequence of a consequence of pregnancy 2  Fetal death it time of death	onto enter the control enter t	rive  ctopic pregnancy  ther (specify)	code 7	23e. Did to	obacco us Yes 2 <b>X</b>	23d. Date of Month see contribu	of delivery	Approximate Interval Between Donset and Death Dea
be completed by rugsicially Medical	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iniqury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 Yes 2 No 9 Unknown  Part II. Other significant condition  Hypertension  25. Was case referred to medical examiner?	omplications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	aconsequence of a consequence of a consequence of pregnancy 2 Fetal death at time of death out not resulting i	onto enter the control of the contro	rive  ctopic pregnancy ther (specify)  erlying cause given in	n Part I.	23e. Did to 1 24a. Was autop perfo 1   Yes	obacco us Yes 2X an ssy rmed? 2 X No	23d. Date o Month se contribu □ No 3 24b. We pric dez 1 □	of delivery  Dute to the Probal re autops ro to compath? Yes 2	Approximate Interval Between Donset and Death Dea
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d. Due to (or as a d. 23c. If yes, outcome 1	a consequence of a cons	onto enter the control of the contro	rive  ctopic pregnancy ther (specify)  erlying cause given in	n Part I.	23e. Did to 1 24a. Was autop perfo to only one) 28 Resid	obacco us Yes 2X an ssy rmed? 2 X No	23d. Date of Month se contribu  No 3  24b. We pric dea 1  Other (c	of delivery  Dute to the Probal re autops ro to compath? Yes 2	Approximate Interval Between Donset and Death Dea
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or cashock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Vo 9   Unknown  Part II. Other significant condition  Hypertension   4  25. Was case referred to medical examiner? 1   Yes 2   No   No   No   27. Manner of Death   Natural   S   Pending	omplications that caused by one cause on each line  a. Adult Fa Due to (or as a b).  Due to (or as a c).  C. Due to (or as a c).  d. 23c. If yes, outcome 1	a consequence of a cons	onto enter the control of the contro	rive  ctopic pregnancy Other (specify)  erlying cause given in  26. Place of the pl	n Part I.	23e. Did to 1 24a. Was autop perfo 1   Yes	obacco us Yes 2X an ssy rmed? 2 X No	23d. Date of Month se contribu  No 3  24b. We pric dea 1  Other (c	of delivery  Dute to the Probal re autops ro to compath? Yes 2	Approximate Interval Between Donset and Death Dea
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inijury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition  Hypertension  25. Was case referred to medical examiner? 1  Yes 2 X No 27. Manner of Death	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown s contributing to death b 401.1  Hospital: 28a. Date of injunt tion to be 28e. Place of Injuntation	aconsequence of a consequence of a conse	ont enter the control of the control	cotopic pregnancy other (specify) erlying cause given in 26. Place of 3 □ DOA Other:  28c. Injury at work?  M 1 □ Yes	n Part I.	23e. Did to 1 24a. Was autor perfo 1   Yes k only one) 28f. Location (S	obacco us  Yes 2X  an  psy  rmed? 2 X No  lence 6  ow injury	23d. Date of Month See contribution of Month	of delivery  Dute to the Probal  re autops or to compath? Yes 2	Approximate Interval Between Donset and Death D
to be completed by Filysicial/Medical	23a. Part 1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iniqury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition  Hypertension  25. Was case referred to medical examiner? 1  Yes 2 No No 27. Manner of Death 1 Natural 5 Pending 2 No 27. Manner of Death 1 Natural 5 Pending 2 No 27. Manner of Death 1 Natural 5 Pending 2 No Suicide 6 Could no C	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1	aconsequence of a consequence of a conse	ont enter the control of the control	cotopic pregnancy other (specify) erlying cause given in 26. Place of 3 □ DOA Other:  28c. Injury at work?  M 1 □ Yes	n Part I.	23e. Did to 1 24a. Was autop perfor 1 — Yes k only one)  Dime 5 X Resid	obacco us  Yes 2X  an  psy  rmed? 2 X No  lence 6  ow injury	23d. Date of Month See contribution of Month	of delivery  Dute to the Probal  re autops or to compath? Yes 2	Approximate Interval Between Donset and Death D
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1	aconsequence of a consequence of pregnancy 2  Fetal death of time of death of the consequence of pregnancy 2  Fetal death of the consequence of the	ont enter the content of the content	Ectopic pregnancy other (specify)  26. Place of 3 □ DOA Other: 4  28c. Injury at work?  M 1 □ Yes, factory, office	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop performer 5 X Residence Res	obbacco us Yes 2X an ssy rmed? 2 X No lence 6 ow injury	23d. Date of Month See contribution of Month	of delivery  Dute to the Probal  re autops or to compath? Yes 2  Specify)  or Rural	Approximate Interval Between Donset and Death Death Donset and Death
be completed by rugsiciall/intedical	23a. Part 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1	aconsequence of a consequence of pregnancy 2 Fetal death at time of death	ont enter the content of the content	cotopic pregnancy ther (specify)  26. Place of a place	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop performed to the can the time, date a abe, and due to the can the time, date a abe, and due to the can the time, date a abe, and due to the time.	bbacco us Yes 2X an ssy rmed? 2 X No lence 6 ow injury street and n, State) use(s) anc nd place, e cause(s)	23d. Date of Month se contribution of Month se contribution of Month se contribution of Months s	of delivery  Dute to the Probal  re autops ro to compath? Yes 2  Specify)  or Rural Re  as stated, the cause or as stated	Approximate Interval Between Donset and Death Donset and Donset Alberta Donset and
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown s contributing to death b 401.1  Hospital: 28a. Date of injun (Month, Day) tion to be ed 28e. Place of Injun building, etc	aconsequence of a consequence of pregnancy 2 Fetal death at time of death	ont enter the content of the content	cictopic pregnancy Other (specify)  26. Place of a book of the control of the con	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop yerfo yers k only one) 28f. Location (S City or Tow	obacco us Yes 2X an ssy rmed? 2 X No dence 6 ow injury street and rn, State) use(s) anc nd place, a cause(s) 29d. Date	23d. Date of Month see contribution of Month see contribution of Month see contribution of Month see contribution of Month see signed (Month see signed (Mon	of delivery  Dute to the Probal  re autops ro to compath? Yes 2  Specify)  or Rural Ro  on the cause as stated.  on the cause as stated.	Approximate Interval Between Driset and Death Driset and Dri
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown s contributing to death b 401.1  Hospital: 28a. Date of injur (Month, Day building, etc.  28e. Place of Injur building, etc.  Physician: To the best of eminer: On the basis of explains of the lurse Practioner: To the law.	a consequence of pregnancy 2   Fetal death at time of death of time	onto enter the content of the conten	rive  ctopic pregnancy ther (specify)  erlying cause given in  26. Place of the specify of the specify of the specify of the specify of the specific of the sp	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop yerfo yers k only one) 28f. Location (S City or Tow	obacco us Yes 2X an ssy rmed? 2 X No dence 6 ow injury street and rn, State) use(s) anc nd place, a cause(s) 29d. Date	23d. Date of Month se contribution of Month se contribution of Month se contribution of Months s	of delivery  Dute to the Probal  re autops ro to compath? Yes 2  Specify)  or Rural Ro  on the cause as stated.  on the cause as stated.	Approximate Interval Between Driset and Death Driset and Dri
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or oshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  Hypertension  25. Was case referred to medical examiner? 1   Yes 2   No   27. Manner of Death 1   Natural   5   Pending   Investigated   Pendical   Pendic	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1 Urive Birth 4 Pregnant a 9 Unknown s contributing to death b 401.1  Hospital: 28a. Date of injur (Month, Day building, etc.  28b. Place of Injur building, etc.  Physician: To the best of endinger: On the basis of endinger: To the later of the	a consequence of pregnancy 2	ont enter the content of the content	rive  ctopic pregnancy other (specify)  erlying cause given in  26. Place of a work?  M 28c. Injury at work?  M 28c. Injury at work?  M 28c. Injury at work?  I yes, factory, office	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop perfo 1 Yes k only one)  28f. Location (S City or Tow and due to the car t the time, date a be, and due to th	obacco us Yes 2X an ssy rmed? 2 X No dence 6 ow injury street and rn, State) use(s) anc nd place, e cause(s) 29d. Date	23d. Date of Month see contribution of Month see contribution of Month see contribution of Month see contribution of Month see signed (Namber of and manner a signed (Namber of American See Signed (Namber of Month see Signed (N	of delivery  Dute to the Probal  re autops ro to compath? Yes 2  Specify)  or Rural Ro  on the cause as stated.  on the cause as stated.	Approximate Interval Between Driset and Death Driset and Dri
to be completed by ruysicially Medical	23a. Part 1. Enter the disease, or o shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Adult Fa Due to (or as a b. Due to (or as a d.  23c. If yes, outcome 1	a consequence of pregnancy 2	ont enter the content of the content	rive  ctopic pregnancy ther (specify)  erlying cause given in  26. Place of the specify of the specify of the specify of the specify of the specific of the sp	n Part I.  of Death (Chec	23e. Did to 1 24a. Was autop perfo 1 Yes k only one)  28f. Location (S City or Tow and due to the car t the time, date a be, and due to th	obacco us Yes 2X an ssy rmed? 2 X No dence 6 ow injury street and rn, State) use(s) anc nd place, e cause(s) 29d. Date	23d. Date of Month see contribution of Month see contribution of Month see contribution of Month see contribution of Month see signed (Namber of and manner a signed (Namber of American See Signed (Namber of Month see Signed (N	of delivery  Dute to the Probal  re autops ro to compath? Yes 2  Specify)  or Rural Ro  on the cause as stated.  on the cause as stated.	Approximate Interval Between Driset and Death Driset and Dri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 12:22 рм Sarah B. Ervin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brooke Grove Nursing & Rehab Center Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral Director** 258-42-6509 1 □ M 2 💢 F April 12,1931 81 Georgia Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is merked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Directo 1 Yes 2 No Highland Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6526 River Clyde Drive 20777 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Ś 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Bank Manager Banking Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ည Isabel Veitch Theodore Bissell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sh Depertment of Health ar Important: If Item 27 is any injury or other trau once. 6526 River Clyde Drive, Highland, Maryland 20777 Robert Ervin - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 11/10/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lice 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myocardial Infarction 11/14/2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ng physician and as the burial-transit Exami or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 1 ☐ Yes 2 💢 No 9 ☐ Unknown signed by the eld be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, cate has been sig ; page 2 should b Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 X Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framinar On the basis of exemination and/or invariant in the cause of exemination and or invariant in the cause of exemination and/or invariant invariant in the cause of exemination and/or invariant in the cause of exemination and or invariant in the cause of exemination and or invariant in the cause of exemination and or invariant invariant in the cause of exemination and or invariant in the cause of exemin 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D35192 November 01, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Gil, M.D., 14816 Physician's Lane, #253, Rockville, Maryland 20850

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 8 2012

32. Registrar' Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 Wilma Ferger 7:43 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pokomoke City Davey's Assisted Living Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 242-01-1266 **Director** 1 □ M 2 F North Carolina Oct. 4, 1916 96 Usual Residence of Decedent permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be not filed any once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21811 5 Oxford Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) General Electric N/A Mold Maker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ Unknown Unknown Witherspoon Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Oxford Court Ocean Pines, Maryland 21811 Ronald J. Ferger (Step-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11/05/2012 Glen Haven Mem. Pk. 21. Signature of Funeral Service Licenses MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Den 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician e mentia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) BOX1733 Salushy WO21802 31. Date filed (Month, Day, Year) State NOV O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
and #1 per PHY &#16a&b&17 Per ANA BD 6934 2/11Copies Are Legible.
and State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Miriam Holdcraft Farlow Day4 1530 M 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death REGIONAL 304/364/4 VICOMICO YENIN SULA MEDIEAL Centu 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 29, 1916 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 217-10-3391 Sual Residence of Decede 1 □ M 2 🖫 F Maryland 95 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland Director XXYes 2 Ki No Salisbury Wicomico MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 300 Lemmon Hill Lane #44 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) retail Own Home retailer Homemaker Be 17. Father's Name (First, Middle, Last) Paul Ellsworth Holdcraft 18. Mother's Name (First, Middle, Maiden Surname) 2 Lola Grace McDonald Paul Elsworth Holdcraft i. Page 1 and 2 should by tment of Health and Mer tant: If item 27 Is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11581 Beckford Ave; Princess Anne, MD 21853 19a. Informant's Name/Relationship (Type, Print) Elaine Warwick - daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Depertment of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 🗓 Donation 5 🗆 Other (Specify) Signature Funeral Service License 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Pat/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ PHEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner AORTIC STENOSIS - CRITICAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami signed by the attending physiclan and defected for use es the buriel-transit DEMENTIA The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been significate has been significated and funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 19 No 1 Tyes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural injury ours after death, leral Director: Ai filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and itle of d ertifie MD D-71972 who completed cause of death (Item 23a) (Type, Print) SAMER 951 ABDUL A. MT HERMON RD

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0

8

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar		State of M	arylar		artmen rtificat			and M		giene Reg. No.	201	2 35	5779
г	_Physici	an	1. Decedent's Name (First, Mi	ddle, Lasi		eri l						2. Date of Dea Month Septembe	ith Day	Yea	3. Time	of Death
	/Medi	cal	GERALD	上	FRIS			44 - 03:				Septemb	7	County of De		5 A M
	Examir	ier	4a. Fecility Name (If not institu	_						Location of Spr:				Montgo		
-	Funeral		Springbrook 5. Social Security Number	6. Se	x 7. A		last birthday)	If Under	1 Year	If Under		8. Date of Birt			Sirthplece (State Country) UTI	e or Foreign
¥.	Director		577-44-8650 Usual Residence of Decedent	1 1	ĎM 2□F	79	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov 28	, 19	32	Country) GIII	
	yland		10a. State 10b. Cou	nty			ty, Town or Lo								10d. Inside	V
	8a-fa	ctor	MD Mo	ntgor	nery	S	ilver S	spring	3							es 2 🖰 No
	d within 72 hours after death with the Maryland Jiene. r than "natural", or items 23a or 28a-f ahow The Medical Examinar must be positived at	ai Director	10e. Street and Number 11235 Oak L	eaf :	Terrace			10f. Zip 20	901				10g. Citi:	zen of What SA	Country?	
	Items	Funerai	11. Marital Status		12. Was Decedent Armed Forces	Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ar Black, W	merican Indian, hite, etc.	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ☐ Divord		Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give	Noullik	i	1 🗆 Yes		Specify:				Specify:	White	
21215-0036	hour htural	ed b	15. Deced		Year or Dates:		16a, Dece	dent's Usua	al Occupa	ation Un	k	1	16b. Kir	nd of Busine	ss/Industry U	nk
215	within 72 ene. than "nat	piet	(Specify only hig Elementary/Secondary (0-1)	hest grad	le completed) College (1-4or	5.4)	(Give	kind of wo DO NOT u	rk done d	luring most	t of workir	ng			,	
212	e fited within the Hygiene. other then	Completed	unk	.,	unk	J+)										
land	o	To Be (	17. Father's Name (First, Midd	le, Last)	unk					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame) l	ınk	
Maryland	ges 1 and 2 should it of Health and Men if Item 27 is marke or other traumatic	-	19a. Informant's Name/Relation				19b. Mailii 112	ng Address	(Street a	and Numbe	er or Aura	Route Numberce; Sil	r, City oi Ver	Town, State Spring	e, Zip Code)	0901
	ges 1 an t of Heal If item 3 or other		20a. Method of Disposition 1 Burial 2 Crematic	n 3 🗆 F	Removal from State	1 1	Place of Dispo cemetery, crea	osition (Nar matory or o	ne of ther place	9)	D	ate	20c. Lo	cation - City	or Town, State	
Baltimore,	t. Pa ntmen ntant: njury		`4 □Donation 5 ☑ Other 21. Signature □ Funeral S. rv	icens	200		22	2. Name an	id Addres	s of Facilit	y Sta	te Anat	omy	Board		
Ö	permi Depa Impo any ir		Cenn	27	Water City	recto	L	655	W. B	altim	nore	St; Bal	timo	ore, M	D 21201	
27	Physician /Medical		23a. Part1. Enter the disease shock, on leart failure. I Immediate Cause (Final disease or condition resulting in death)	or comp ist only o	a. CAT	ine. 201 <sub>1</sub>	AC:	ter the mod	le of dying	such as	cardiac o	r respiratory ar	rest,		Approxin Interval E Onset an	Between
	Examiner				Due to (or as	a consec	AP (	CAN	CE	2					Mon	VTHS
	ate be executed hysicien and he burial-transit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to (or as											
8760,	ate be e hysicien the buriz	cal	d													
.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph age 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date of d Month			delivery Day	Year	
<u>α</u>	w requires that been signed by should be deta	by	Part II. Other significant cond		-		-	nderlying c	ause give	n in Part I.			bacco u		to the cause of	of death?
Sor	y requ	etec	20111192	11		<u></u>	1 6									
Vital Records,		Completed													autopsy finding to completion of ? 'es 20 No	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to med examiner?	110	lospital:				Othe		of Death	(Check only o	ne)			
ō	Phy ral d	on: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1/2 Natural 5 ☐ Pen		1 ☐ Inpati 28a. Date of Inju (Month, Da	ury	28b. Time o Injury		Bc. Injury Work	at Nu		ne 5 Resid			pecify)	
Division	Attending or death. rector: After by the fune	Certification:	2 Accident inve	stigation	n M 1 ☐ Yes 2 ☐ No  188						28f. Location (S City or Tow			Rural Route N	umber,	
Ö	spital or ours afte neral Dir filled in			vina Phy	building, e			h occurred	at the tim	e date an	d place, a				as stated.	1
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medic	al Exami	ner: On the basis of and manner st	of examina	ation and/or in	vestigation	, in my op	inion, dea	th occurre	ed at the time,	date and	place, and o	due to the caus	
\	5 <u>4 5 5</u>	<	29b. Signature and title of cert	ıer					. License					e signed (Mi	onth, Dey, Year	2512
7		i	30. Name ess per	n who co	ompleted cause of	death (Iter	n 23a) (Type,	Print)			5	to #15	) 2.	Pari	(21,0	cil
			KANITA	155	1 ND /3	24	5 547	AD 4	GRO	OVE	KOI	TU #1	D.	NUCK	-VILLE	
	Sta Registr		NOV 0 8 2	012	32. Regist	rar's Signa	park	-						114	1408	30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Bernice S. Gilbert 2012 11:25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11430 Strand Orive #409 Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min, Hours 97 Director 295-26-6275 1 □ M 2 🛱 F West Virginia 10-2D-1915 Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MD Rockville Montgomery 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23e Funeral 11430 Strand Drive 20852 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file in and Mental H is marked of (Unknown) Isadore Steckler Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a item 27 is 6705 Arroyo Court, Rockville, Maryland 20852 Mark David Groban - Son Department of Hear Important: If itemany Initial Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 10-26-2012 Clarksburg, Maryland 21. Signature of Funeral Service Licensee Edward Sagel 22. Name and Address of Facility Edward Sagel Funeral Oirection 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction minutes Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No this certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 🗌 Yes 2 🔯 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of tifier 29c. License number 29d. Date signed (Month. Day, Year) 1D-25-2D12 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Mildred

evin

Barry Rosenbaum, MD - 3720 Farragut Avenue, Kensington, Maryland 2D895

Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Richard Gravatt JR. 10:28 PM John October Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Harbor Baltimore Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec. 10, 1955 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-58-6627 Hours Mary Land **Director** 1 🔀 M 2 🗆 F 56 Usual Residence of Dece 10b. County N/A shov 10c. City, Town or Location Baltimore 10d. Inside City Limits at the Maryland **Funeral Director** Maryland items 23a or 28a-f s ier must be notified 1 Yes 2 ☐ No 10f. Zip Code 21230 10e. Street and Number 1430 South Charles Street 10g. Citizen of What Country? U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner r 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 X Divorced Specify: White Completed Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Carpentry Be Father's Name (First, Middle, Last)
John R. Gravatt, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Shirley Kurth ည 9a. Informant's Name/Relationship (Type, Print)

Debbie Cage (Care Giver) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 1430 Sout: h Charles Street Baltimore, Maryland 21230 of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Department o Important: If any injury or once, #: 5 Cedar Hill Cemetery Nov. 6, 2012 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Mary Polyniak Funeral Home, P.A. 130 East Fort Ave. Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Ph\_sici\_n 5hock Saptic disease or condition weeks Medical resulting in death) Due to (or s a consequence of): **Examiner** weeks Myocardial Sequentially list conditions Examine if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the al detached f been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performe 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 🗌 Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES 00 | ND November, 2nd, 2012

MDHMH 17 Rev 06-2011

State

Registrar

Hanover Street

Bultimore

21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

31. Date filed (Month, Day, Year)

NOVO

South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 1:15 AM M September Medical <u>Elva Marlene Glenn</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Forest hill Rock Spring Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 86 Director 492-24-7308 1 🗆 M 2 🗓 F <u>May 31, 1</u>926 Missouri 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No Forest Hill Harford MD 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code ò must be Funeral 23a USA 21050 1 Colgate Dr. death al Hygiene.
of other than "natural", or items event, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) sales Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Ella Gertrude McWilliams Aubrey Virgil Grottweil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Silver Beech Ct; Bel Air, MD 21015 Steel H. Glenn - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Signaur - Funeral Service Licen 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has heen sinned by the control of attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) been signed by the a should be detached Part II, **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HB 6 24a. Was an After this certificate has funeral director, page 2 2 No Yes 1 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

29b. Signature and title of certifie

DAVE

2

(15 200 w 31. Date filed (Month, Day, Year) 22:-Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

arke

29c. License number

03225

29d. Date signed (Month, Day, Year)

Ochles 27, 201 -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Year 12 Gerald 0238 Greenfield Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltinore NIA Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 72 579-52-4626 Director 1 XM 2 □ F June 30, 1940 Washington DC 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits must be notified at Director 1 Yes 2 X No DC ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21223 1943 W. Baltimore St. items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ral", or iten Examiner þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 👿 No Specify: "natural", Completed 3

Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) apartment complex maintenance man Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ t. Page 1 and 2 should be thent of Health and Mentant: If item 27 is marke other traumatic  $\begin{array}{ll} \mbox{Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)} \\ 2005 \mbox{ Richglen Dr; Baltimore, MD 21207} \end{array}$ 19a. Informant's Name/Relationship (Type, Print) Brett Thomas - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 

Burial 2 

Cremation 3 

Removal from State 4 ☐ Donation 5 🖫 Other (Specify) in state Sindur of Funeral Selice License Roma de S 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ hypoxic respiratory disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial. Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear Pregnant at time of death To the Funeral Director. After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal disease, hypertension 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed Banda 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: ဂ္ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ within 2 To the ! only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

John Marko M.D.

Macht

NOV 0 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S Greene

Street

29c. License number

1437424538 (NPI

Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

10/16/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		epartment of F Certificate of I			ene 2016	2 35781
			Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	3. Time of Death
~4	Physicia /Medic		Albert	Gist	Sr	•		10-24	-2012	3:30P M
	Examin	er	4a. Facility Name (If not institution, g				Location of Death		4c. County of Death	1
- 00	Funeral		3422 55th <i>A</i> 5. Social Security Number 6.		(In yrs. last birth	day) If Under 1 Year	ttsvill	8. Date of Birth (Month, Day, Y	PG 9. Birth	nplace (State or Foreign untry)
	Director		578-38-1499	1 <b>½</b> M 2□ F	83 Y	rs. Months Days	Hours Min.	July 4,	1929	ŠC
	and ow t		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary I-f sho fied a	tor	MD PO	3	Hyatts	sville				1 ∏Yes 2 ☐ No
	or 28a e noti	Jirec	10e. Street and Number			10f. Zip Code		10g	, Citizen of What Cou	untry?
	ath wi	rall	3422 55th Aver			207			U.S.	ion Indian
	ter de items	Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent E Armed Forces? 1 □Yes 2 XN		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the "hoursal Examiner must be notified at	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify: B	lack
2-0	72 ho	etec	15. Decedent's l (Specify only highest g	Education rade completed)	I (	Decedent's Usual Occup Give kind of work done	during most of work		6b. Kind of Business/I	ndustry
12	within iene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	life. DO NOT use retired actor Tra		iver	Self	
<u>ام</u>	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Las					e (First, Middle, Ma		
ylar	should be I and Mental s marked o umatic eve	To E	invikn	1000				Corrie	Gist	
Mar	. co co =		19a. Informant's Name/Relationship Albert Gist Jr	, ,		Mailing Address (Street) 42 Blacks				
<u>စ</u> ်	1 and 2 Health tem 27 i		20a. Method of Disposition	(5011)		Disposition (Name of crematory or other place			oc. Location - City or	
altimore,	Pages nent of int: If its iry or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	ny Mem. P	i	05-12	Landover	MD
a	permit. Page Department ( Important: If any Injury or once.		21. Signature of Funeral Service Lic			22. Name and Addre	ss of Facility Te	rry A.	Austin F	un. Serv.
<u> </u>	207 2 2		1 8/19			3821 14t	h Stree	t NW Y	Wash DC	20011 Approximate
Ł			23a. Part 1. Enter the disease, or co shock, or heart-failure. List on Immediate Cause (Final			ot enter the mode of dylf	ng, such as cardiac	or respiratory arres	il,	Interval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	a. CV A	r consednence o	n:				
and a	Examiner				PERTENS					
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a	consequence o	f):				
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	consequence of	f):		<u></u>		
68760,	ificate be executed physician and is the burial-transit	edical E		_d.						
	rtifical ng phy	Medi	IF FEMALE:				- 192			
Box	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal death	3 Ectopic pregnance	ey .		23d. Date of del Month	ivery Day Year
o.	uires that the de signed by the a d be detached f	ıysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	ume or death	5 ☐ Other (specify) _				
ر. ص	s that med b e deta	by Pr	Part II. Other significant conditions	_	t not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	v require been sig should b		DIABETE	ES, COPD				1 ☐ Yes	2 No 3 Pr	obably 4X Unknown
ပ္တ	law n has be e 2 sh	Completed						24a. Was an autopsy	prior to	itopsy findings available completion of cause of
a E	sician; The Is certificate ha irector, page 2							performe 1 □Yes 2	No 1 □ Yes	2 □ No
₹	/sicial s certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1   Inpatie	nt 2 □ ER/Out	patient 3 DOA Oth	or:	th <i>(Check only one)</i> ome 5 <b>⊠</b> Residen	nce 6 ⊡Other (Spe	cify)
o c	ng Phy fter thi neral (	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. T			28d. Describe how		
Sio	tendii eath. tor: A the fu	catic	2 Accident investigat 3 Suicide 6 Could not			M 1 □	Yes 2□No	00f L		- ( Doub Alumba
Division of Vital Records,	I or At after o Direc	Certification: To	4 ☐ Homicide determine	building, etc	: (Specify)	m, street, factory, office		City or Town,	eet and Number or Ru State)	arar noute ivamber,
	ospital hours ineral y fillec		29a. Certifier 1X Certifying	Physician: To the best of aminer: On the basis of	of my knowledge	, death occurred at the t	ime, date and place	e, and due to the ca	use(s) and manner as	s stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director; p.	ledical	one)	aminer: On the basis o						
	viit cor	Σ	29b. Signature and title of certifier			29c. Licens	068418		d. Date signed (Mont $10 ext{}30 ext{}12$	n, Day, Tear)
	.\ /		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (	. 0	000410		10-00-12	
	HV		Christopher			Mercantil	e Ln.,	Largo,	MD 20774	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					
	Registr	ar	NOVO 8	2012 / Dear	w 1.	Sarke				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rita Gunsher October 2012 7:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 084-24-8057 1 □ M 2X F 81 New York March 15,1931 I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Derwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16835 Bethavres Rd. 20855 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. Completed 3 Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Engineer Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk h and Mental ? 7 is marked o 2 Bank (Unknown) Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam G. Columba / Daughter 1 and 2 s of Health item 27 16835 Bethayres Rd., Derwood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 11/02/2012 Beltsville, MD 21. Signature of Furreral Service Licenses 22. Name and Address of Facility. Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Gist Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) y physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 for use as attending yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year signed by the at Id be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, cate has been signated by page 2 should by 1 Yes XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law in 24 hours after death.
 Funeral Director: After this certificate has be letely filled in by the funeral director, page 2 s performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🕅 Other (Specify) HOSPICE 1 🗌 Yes 2 💢 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signafure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 10.27.12

81

Registrar

DHMH 17 Rev 06-2011

State

6001 MUNCASTER MILL RD., ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DEBRAH MILLER, CRNP

31. Date filed (Month, Day, Year) . \_\_. .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 07 2012 HATCHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CLC LOCH RAVEN BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 1 MM 2 D F 04/09 11928 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral Wrenwood 21212 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces' Black, White, etc.

Specify: AFFLICAN 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced AMERICAN 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) SPARROWS Hoins Elementary/Secondary (0-12) College (1-4 or 5+) Tractor Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 FRED Hatcher Trent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Dorothy Ave - BALTIMORE, MD . 21212 Wrenwood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State BATTIMORE, Md 11-19-12 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGhn GREENE FUNERAL SCUT PA York Road . Baltimore, MD . 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CARCINOMA OF disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate for the following the following cause (Disease or injury that initiated events Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of). ate has been signed by the attending physician page 2 should be detached for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 9 Unknown a I Inknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number willen, D30272 NOVEMBER 07, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32 Registrar's Signator

3900 LOCK RAYEN BOULEVARD

BALTIMONE MD 21218

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

person who completed cause of death (Item 23a) (Type, Print) ALL ALL FLANALS B V26,

D0053094

DO014

29d. Date signed (Month, Day, Year)

11-02-2012 11/02/2017

ATTENDING MD

- Deputy MIE.

F JEWSEW MO, POB #690 DENTON
Year) 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland				Mental Hyg	jiene	
			State Registrar		Cer	tificate of E	eath		leg. No.	100570
	Physicia Medic		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	26 201	2 2 18 A M
-	Examin	er	4a. Facility Name (if not institution, give stre	,		4b. City, Town, or		th	4c. County of De	eath
manus de la constitución de la c	Funeral		Future Care Char1  5. Social Security Number 6. Sex	es Village  7. Age (In yrs. Ias	st hirthday)	Baltim If Under 1 Year		s. 8. Date of Birth		Birthplace (State or Foreign
	Director			# 2 <b>∏</b> F 84	Yrs.	Months Days	Hours Mir		Year) (	Country) unk
	and show	ō	10a. State 10b. County	10c. City,	Town or Loc	ation		Journe 7,	1720	10d. Inside City Limits
	Maryl:	Director	MD	Ва	ltimo:	re				1 🌠 Yes 2 🗌 No
	a or 2	i D	10e. Street and Number	•		10f. Zip Code			10g. Citizen of What	Country?
	th with	Funeral	3308 Chestnut Av		I		1211		USA	
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marked Examinar must be in titled at or other traumatic event, the Marked Examinar must be in titled at	ρ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces?  1 Yes 2X No If Yes, Give Year or Dates.	H	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 [X] No	n, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, Wh Specify: To	
5-0	Phour	plet	15. Decedent's Educa (Specify only highest grade	ation		ent's Usual Occupa		unk	16b. Kind of Busines	ss/Industry unit
121	hin 72 ne. than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO	NOT use retired)	uning most or we	JI KING		
Q 7	ed wit Hygie other ent, III	0	unk ur 17. Father's Name (First, Middle, Last)	ık.		unk	18 Mother's N	ame (First, Middle, N	Asiden Sumame)	unk
lan	l be fil lental rked c	P	,,,,			dirk	TO. MOUTE STA	arre (i iist, middle, n	nauch samame)	GIII
Mary	d 2 should alth and M 1 <b>27 is ma</b> or trauma'		19a. Informant's Name/Relationship (Type, Future Care Charle						City or Town, State,	
Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iterr ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☒ Other (Specify)	noval from State ce		sition (Name of natory or other plac	θ)	Date	20c. Location - City	or Town, State
Balti	permit. Page Department of Important: If any injury or once,		21. Sign turn of runeral Service Lio n as	de, Director	St	Name and Addres ate Anato ltimore.	omy Bóar		Baltimore	Street
			23a. Par 1. Enter the disease, or complication shock, or heart failure. List only one of	tions that caused the death. ause on each line.	. Do not ente	r the mode of dying	, such as cardia	c or respiratory arre	est,	Approximate Interval Between
F	nysician/	ē W	Immediate Cause (Final disease or condition	cardiothr	ombot	ic Eve	nt			Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a conseque		- and inves	send -	disease	7	
		ě	So quentially list conditions b.	Due to (or as a conseque		araiova	singr	alsease		
	rted d ansit	amir	cause. Enter Underlying Cause (Disease or injury							
	ate be executed ohysiclan and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
		edic	d.							
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as it	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of o	23d. Date of delivery Month Day Year					
P.O.	that th	y Ph	Part II. Other significant conditions contri	buting to death but not resul	lting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ds,	quires en sigi ould b	ted k						1 □ Ye	es 2 No 3 🗆	Probably 4 🗌 Unknown
Recor	≥ 0,0	Completed						24a. Was ar autops perform 1 \(\sum \) Yes	sy prior t med? death	autopsy findings available ocompletion of cause
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	pital:			ace of De th (Ch	eck only one)	•	
Į.	Physi this o	<u>ان</u>	1 Yes 2 No	1 ☐ Inpatient 2 ☐ E	R/Outpatien 28b. Time of		4 M Nursing		ence 6 Other (Sp	ecify)
0 0	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work M 1 🗆		28d. Describe ho	w injury occurred	
ivisio	al or Atter s after dea l Director d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Location (Sta City or Town	reet and Number or I n, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check 2 L. Medical Examiner:	n: To the best of my knowled On the basis of examination a ractitioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred	d at the time, date an	d place, and due to the	e cause(s) and manner stated.
	Vithi To th	-	29b. Signature and title of certifier.	1	<u> </u>	29c. License	number	2	9d. Date signed (Moi	nth, Day, Year)
	1cm		> mshuppe			Æ	00574	65	10/26	
	1911.		30. Name and address of person who com	10 2835.	Smil	rint) NV S	203 7	Balt ma	HE MO	21209
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 0 8 2012	32 Registrar's Signatu	. pa	Mal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ HARRINGTON 00:51AM TOSEPH 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BALTIMORE GOOD SAMARITAN If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 218-38-3198 1 X M 2 D F April 1, 1943 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Ves 2 No Parkville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21234 USA 8710 Emge Rd. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 N Divorced Completed Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) construction heavy equipment operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Clara Kegley Claude Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 190 RD2; Delta; PA 17314 19a. Informant's Name/Relationship (Type, Print) .. Page 1 and 2 st tment of Health a Lois Alies - sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Sig ator of Euneral Service License 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYOCAR DIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner SHOCK  $\pi c$ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Directo for as a completions of Cause (Disease or injury as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) for use a 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year signed by the at Id be detached for g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should KIDNEY INJURY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific Division of Vital 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO 10/20/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr Jerusha Naidoo, 5601 Loch RAVEN BLUD, BALTIMORE, MD, 21239

State Registrar

DHMH 17 Rev 06-2011

riegistrai

31. Date filed (Month, Day, Year)

back

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Da 1955 Michael Haris November 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Gilchrist Hospice 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days 219-48-9729 Director 1 ØM 2 □ F Yrs July 13, New York 1946 66 in then "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5812 Wyndham Circle, U.S.A. 21044 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Š 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | h and Mental Hyglene. 7 is marked other then "n College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Regional Supervisor State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evlavia Michael Styllianos Charalambous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sh Department of Health ar Important: If Item 27 is any injury or other treu 4509 Rusty Gate, Ellicott City, Maryland 21043 Stephania Thompson - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk. 11/08/2012 Rockville, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Li 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Melastatre Physician/ disease or condition Medical resulting in death) Examiner equentially list conditions, f any, leading to immediate cause [Disease or injury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No <u>|</u>2 pica 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/2 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

Registrar

CEDAR

6336

32. Registraris Signature

21044

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ABBAS

8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 3579 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lois Inez Hamberger 2012 4:45 am November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 12005 Golden Twig Court 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours Months 214-26-9498 Director 1 □ M 2 🛛 F 84 March 07.1928 Maryland Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 28a-f Gaithersburg 1 Tes 2 X No Maruland Montgomery 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? U.S.A. 20878 12005 Golden Twig Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ٥. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White "natural" Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Morton Rosenberg Miriam Sneidman and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 12005 Golden Twig Court, Gaithersburg, MD 20878 Harold Levy/Son-in-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗴 Burial 2 □ Cremation 3 💢 Removal from State King David Mem Grdns | 11/04/2012 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cancer of the Tongue and Larynx Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Year Pregnant at time of death Day ed by the a detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No this certificate 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, i 24 hours after death.

E Funeral Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29d. Date signed (Month, Day, Year) November 02, 2012 D37142

Registrar

DHMH 17 Rev 06-2011

Geoffrey Coleman, M.D., 1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Simature

31. Date filed (Month, Day, Year)

NOV 0 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ 2012<sup>ear</sup> October 4° 3:58 P Frances HONEYMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Hebrew Home of Greater Washington 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Dct. 30, Hours Year 920 New York 1 🗆 M 2 🙀 F 91 Director 130-03-0607 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No 20852 Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20852 6105 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Marion Ida Murray Walshin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8812 Higdon Drive, Vienna, VA 22182 19a. Informant's Name/Relationship (Type, Print) Alan Sibarium, Stepson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 10/07/12 New Britain, CT Alom Cemetery of theral Service Licenses Törchinsky Hebrew Funeral Home 20012 Carroll St NW, Washington, explications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Par Lanter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician neumonea disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗵 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred injury s after dec. 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tazli, MD

D0064871

6121 Montrose Rd Rockwille.

10-4-2012

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ROBERT HAZEL October 2012 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Futurecare Homewood Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min **Director** 215-76-6343 1**X** M 2 □ F 56 Yrs Jan. 14,1956 Maryland Usual Residence of Decedent 28a-f show with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3035 Shannon Dr. 21213 United States filed within 72 hours after death all Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XXNo 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify. Black Specify: Completed 3 Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Menta (Unknown) Lilliem Haze1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau Amanda Pope / Sister 3035 Shannon Dr., Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Uniformed Sers. Univ. 11/06/2012 Bethesda, MD 21. Signature of Funeral Se M00382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Cardiomyopathu disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of). cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed should Were autopsy findings available prior to completion of cause of hours after death. Ineral Director. After this certificate has l by filled in by the funeral director, page 2? autopsy performed Yes 2.0 death? 2 🗌 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other 2 **(**10 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical

To the Hospital or within 24 hours at To the Funeral D

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

only one) 29b. Signature and title of certifier

Raymond

31. Date filed (Month, Day, Year)

Miller

NOVO 8

mille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box

MO

1525

OWINES

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D47683

21117

29d. Date signed (Month, Day, Year)

1931/12

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MILL MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 2012 Kenneth Michael Holmes 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2015 Ramsay Street Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Hours 219-80-6612 Director 53 1**X** M 2 □ F May 23,1959 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Importent: If item 27 is marked other then "natural", or items 23a or 28e-f show any Injury or other treumetic event, the Medical Examiner must be notified at once. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 H Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2015 Ramsay Street 21223 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William A. Holmes, Sr. Mildred E. Herold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Ramsay Street Baltimore, MD 21223 Patricia A. Brown / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Park Cemetery Nov.5,2012 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of Funeral Service Licen 2719 Hammonds Ferry Road Lansodwne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-transl the Hospitel or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown 1 Yes 2 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? Was an has autopsy After this certificate ☐ Yes 1 ☐ Yes 2 ☐ No 2. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury erel Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my project. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bach 140 2120 CONSTUTS BUCK 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:49 ovembe Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death 9 かいしてい **Funeral** If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min 529-20-9739 **Director** M 2 □ F 1925 Utah June 30, 28a-f shov the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗆 Yes 2 🗓 No Pasadena Anne Arundel Marvland items 23a or 2 ner must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 214 Dale Road U.S.A. "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced 1946 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Kennecott Refining Co. General Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) of Health and Mental H f item 27 is marked of r other traumatic ever မ Johnson Ear1 June Jensen Myrtle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Karen Shepke (Daughter) 35 Glen Road Pasadena, Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g Date Department of Important: If it any injury or c 1 🕅 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) Crownsville V.A. Cem: 11/15/2012 Crownsville, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P. 3204 Mountain Road Pasadena, Mary Signature of Funeral Service Licensee MOO-732 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Thy victary disease or condition resulting in death) Medical Due to for as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 as the t IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for L 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year the ; 1 Li Yes 2 2 signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of r this certificate has be eral director, page 2 s the Hospital or Attending Physician: The law autopsy performed Yes 2 death? Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 No Accident Investigation within 24 hours after death

To the Funeral Director; of the Funeral Director; of the completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Jackson-Minor 10:35A /Medical 10/18/2012 4a. Facility Name (If not institution, give street and number) 4c. County of Death  $\mathbf{PG}$ 4b. City, Town, or Location of Death Examiner Waldorf, MD 3221 Nobility Court If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F Director 73 578-52-6521 4/14/1939 Wash.,DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Wedical Examinar must be redified at Director Waldorf 1 XYes 2 No PG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3221 Nobility Court 20603 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No ρ Specify. Specify: Black 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private is 1 and 2 should be filed vor Health and Mental Hygie item 27 is marked other 27 is Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ina Christine Powell Woodrow Wilson Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3221 Nobility Court, Waldorf, MD 20603 Marcia Bess - Daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/26/12 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 21. Signature of Funeral Service Freeman Funeral Services 4594 Beech Rd, Temple Hills, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a year 1 g to initio date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. | the 9 ☐ Unknown 9 Unknown signed by the best of the sign 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 212 No this certificate 1 ☐ Yes 2 No 1 Tyes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Autural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a tight certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K00

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dilmus L. Jarrett Jr 2012 4:15 PM M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 225-28-0145 1 XM 2 F 89 Jan 21, 1923 Virginia Usual Residence of Deced th and Mantal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show treumetic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Directo 1 Yes 2 No MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 910 Rosalie Drive 21802 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. ģ 1  $\square$  Never Married 2  $\cancel{\mathbb{K}}$  Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Year or Dates. 143-45 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) flight service specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Haalth and Mantal H item 27 Is marked of မ Dilmus Lyle Jarrett Sr Lillie Adeline Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Rosalie Drive Salisbury, MD Ann Jarrett/spouse 21802 parmit. Page 1 and 2 Dapartmant of Haaltl Important: if item 2 any injury or other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Euparal Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 0 23a. Part 1 Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Immediate Ca (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir attanding physician and I for use as tha burial-transit Tha law requiras that the daath cartificate ba axacuted Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at I ba datachad f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Onknown paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificata has autopsy performed 2 1 No Yes 2 No 1 Yes To the Funerei Diractor: Aftar this cartifica complataly fillad in by tha funeral director, Physicien: 25. Was case referred to nedical æ 26. Place of Death (Check only one) Hospital Other: မြ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of I or Attending F after daath. 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funerel D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier s of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23, 2012 **Physician** 8:10 PM October Dorothy Mae Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Overlea Health & Rehabiliation Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1924 Country) Maryland Hours Days 1 □ M 2 🖾 F March 4, 88 Director 220-18-3737 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Examiner must be rediffied a once. 1 ☑Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 6116 Belair Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ≥ 3 ₩ Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) food industry waitress 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gladys Kelley Leroy Astor Franklin ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9707 Liberty Rd #417; Randallstown, MD 21133 19a. Informant's Name/Relationship (Type. Print) Rosalie Johnson - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 3 ☐ Removal from State 1 ☐ Burial 2 ☐ Cremation 4 Nonation 5 Dotter (Specify) 21. Signature of Juneral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Filter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physiclan: The law requires that the death certificate be executed resulting in death) Last Box 68760; Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 nonths?

1 Yes 2 No
9 Unknown Month 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▶ 10 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Teath
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29c. License number 39/ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certicause of death (Item 23a) (Type, Print) Raven Blvd, Battimore M2123

DHMH 17 Rev 1/2001

State Registrar Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ZOPM **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Manor Care - Ruxton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Yrs Director 88 April 28 1924 MD 219-16-6883 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 □Yes 🏌 □No Director MD Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ural", or items 23a or Examiner must be 21093 USA 200 Belmont Forest Ct. Unit 306 Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo white Specify: Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) McCormick Spice Co. Facilities Manager les 1 and 2 should be filed vor Health and Mental Hygie of Health and Mental Hygie if Item 27 Is marked other to other traumatic event, the other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျ Birdie C. Jones Addie Trego 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Belmont Forest Ct., Unit 306, Timonium, MD 2109 Mrs. Thelma H. Jones/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/9/12 Gardens 4 Donation 5 Dother (Specify) Dulaney Valley Memorial Timonium, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 3 ☐ Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wirknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 J. No 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner J. Prath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 roslendue Fulk 205 Janson Mp211a, 30. Nam and ad re s MIL

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State	State of Mar		artment of I			2.0	12 35800	
			Registrar  1. Decedent's Name (First, Middle, Las	et)	Cei	uncate of t	Jeani	2. Date of Dea	Reg. No.	1 00000	
	Physicia	n/		Bessie	Koontz				er <sup>Day</sup> , 20 <sup>Ye</sup>	3. Time of Death 2 12:45 AM	
	Medic		4a. Facility Name (if not institution, give		ROOMEZ	4h City Tours o	r Location of Death		4c. County of E		
1	Examin	er	Bedford Court	Stroot and Hambory		Silver			Montg		
	Funeral		Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		h 9.	Birthplace (State or Foreign	
	Director		578-07-9407	□ M 2 □ F	92 Yrs.	Months Days	Hours Min.	Sept 4,	1920 V	Country) irginia	
	M		Usual Residence of Decedent								
	yland f sho ed at	호	10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits	
	Mar 28a- otifie	ire	Maryland Montgom	lery	Rockvil					1 □XYes 2 □ No	
	th the	al	10e. Street and Number			10f. Zip Code 2085	.0		10g. Citizen of What U.S.A.	Country?	
	th with ms 2 must	<b>Funeral Director</b>	641 Blossom Drive	12. Was Decedent Eve		Was Decedent of H		negify Vec or No		Lucrotic and American	
10	r dea	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces?  1  Yes 2 And	3 11 0.5.	f Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		American Indian, Vhite, etc.	
ဗ္ဗ	s afte "al", c Exan	g p	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	ı ı	1 ☐ Yes 2 🂢 No	Specify:		Specify:	White	
Ŏ	hour natur sical	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	ald + -	16b. Kind of Busin	ess Industry	
7	e. Ban "	崩	(Specify only highest gri Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	kind of work done O NOT use retired)		_			
7	ygien ygien her tl	രി	12		Admin	istrative			Governme	nt	
Maryland 21215-0036	e filed tal H ed ot ever	To B	17. Father's Name (First, Middle, Last)  Edward Trickle So	choonover					Maiden Surname) McCarthy		
ž	mark mark	-			101 11 11				-		
Ma	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	li	19a. Informant's Name/Relationship (7)  Vancelle Koontz J			_			; City or Town, State		
ē,	and Heal tem		20a. Method of Disposition	Ones (Badgi	20b. Place of Dispo	sition (Name of	!	Date	20c. Location - Cit		
no	age 1 ent of st; # i		1 ☐ Burial 2 🔣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		cemetery, crei	matory`or other pla itan Cren	ce) natory 11	/8/2012	Alexand	ria, VA	
Baltimore,	artm. Partm. oortar injur		21. Sign Ture of Funeral Service Licens			2. Name and Addre					
ñ	permit Depar Impor any in		July 131	joerds	$\frac{1}{5}$	etropolit 517 Vine	St., Ale	al Servi xandria,	VA 22310		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the	ne death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between	
٦,	hytician/		Immediate Cause (Final disease or condition	Cerebro	vascular	Accident				Onset and Death	
	Medical Examiner		resulting in death)	Due to (or as a c	consequence of):						
	=xaminer	<u>.</u>	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury  Due to (or as a consequence of):								
	sit sit	Examiner									
	and I-tran	Exal	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
0	icate be executed is the burial-transit	dical		d							
292	icate g physis the	ledi		- d							
89	eath certifice attending p	J.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2		☐ Ectopic pregnan	CV		23d. Date o	f delivery	
Box 687	death le atte	sicis	in the past 12 months? 1  Yes 2 No	4 Pregnant at ti		Other (specify)	oy .		Month	Day Year	
<u>.</u>	res that the death signed by the atted be detached for	Physician/Me	9 Unknown					00 8111			
σ.	s tha igned be de	by	Part II. Other significant conditions of Multi-Infarct		not resulting in the t	andenying cause g	iven in Fait i.			te to the cause of death?	
rds	v require been si should	ted	Tiurer Impares	DOMOTIVE					1 Yes 2 No 3 Probably 4 Uni		
00	law re nas b	Completed						24a. Was autop		e autopsy findings available r to completion of cause of	
æ	The cate page	Ö						1 🗆 Yes	2 <b>X</b> No 1 L	Yes 2 No	
ta	ician Sertifi ector	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Oth	lace of Death (Che				
<u>_</u>	Phys this	2	1 Yes 2 No 27. Manner of Death	1 Inpatien 28a. Date of injury	t 2 ER/Outpatie	nt 3 L DOA	4 A Nursing I	T	dence 6 Other (S	Specify)	
u o	ding th. After fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day,	Year) injury	wor	y at 28d. Describe how injury occurred? Yes 2 \( \subseteq \text{No} \)				
Sio	Atter	Certificate:	3 Suicide 6 Could not b	28e. Place of Injury	- At home, farm, str	reet, factory, office				r Rural Route Number,	
Division of Vital Records, P.O.	sales sale			building, etc. (	(Ѕресіту)			City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		ysician: To the best of miner: On the basis of exa						s stated. the cause(s) and manner stated.	
	the thin 2 the function 2 the function 2 the function 2 the function 3 the functi	M	only one) 3 Certifying Nur 29b. Signature and title of certifier	rse Practioner: To the be	est of my knowledge,	death occurred at the 29c. Licens			e cause(s) and manne 29d. Date signed (M		
	<b>5.≥ 6</b> 8		200. Orgination and the or continor	2000	44.		3443		November		
	)		30. Name and address of person who	completed cause of dor	ath (Item 23a) (Type.	Print)					
			Alan Pollack,		even Locks	s Road Ro	ckville,	MD			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2012	32. Registrar's	s Signature						

DHMH 17 Rev 7/2009

7	KO-	A	Pleäse Type or F	Print in Black I Maryland / Dep					
11		-	State Registrar	,	ertificate of L		ĺ	Reg. No. 2012	35801
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Rose L. Kople	, TN			2. Date of De Month	Day Jear	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give street and number \$3011 Falstoff Rd. A	15t. 602 A	Bal	Location of Death	re	4c. County of Dea	
	Funeral Director		5. Social Security Number  215-10-9130  Usual Residence of Decedent	Age (In yrs. last birthday, 94 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar	ay, Year) Co	rthplace (State or Foreign ountry) [aryland
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	Director	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a	Funeral	3011 Falstaff Rd. Apt.	602A	2120	9		United	States
	death item ner m	Ē	11. Marital Status 12. Was Decede Armed Force	es?	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
9000	rurs after tural", or al Examii	ted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give Year or Date	es.	1  Yes 2			Specify:	White
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "hatural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	or 5+) (Giv	edent's Usual Occup e kind of work done of DO NOT use retired)	during most of worl	king	16b. Kind of Business Own Hom	
9	ed wil Hygie other ent, th	Be (	12   17. Father's Name (First, Middle, Last)	Ho	ome Maker	18, Mother's Nan	ne (First, Middle	, Maiden Surname)	e
Maryland	be fillental rked c	욘	Phillip Zussman			Ida	Himelfar	rb	
ary	hould and M is mai		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, State, Z	ip Code)
Σ	and 2 s Health a tem 27 i		Michael H. Kaplan /Son	2	441 Pickw	ick Road	Gwynn (	Oak, MD 212	
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1		20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	late	position (Name of rematory or other place nore Hebre	i	Date Nov 05 rs 2012	20c. Location - City o	rTown, State
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility Fu	neral Al	ternatives	vland 21286
	Pnysician/		23a. Part 1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	Asziration					Approximate Interval Between Onset and Geath
Second Second	Medical Examiner	<u>.</u>	Sequentially list conditions, b.						
	ted I Insit	Examiner	Cause (Disease or injury	as a consequence of):					
00	e be execu ysician and ne burial-tra								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	23b. was decedent pregnant	ant at time of death 5	E Ctopic pregnand Other (specify)	су		23d. Date of d Month	elivery Day Year
s, P.O.	res that th signed by d be detad	d by Ph	Part II. Other significant conditions contributing to dea	ith but not resulting in the	e underlying cause gi	ven in Part I.		tobacco use contribute	to the cause of death?
Records,	S S S	omplete	Memory Loss Hyper of Undetermined Significan	e			perf	opsy prior to formed? death?	utopsy findings available occmpletion of cause of
E E	an: Th tificat tor, pa	Be C	25. Was case referred to medical		26. P	lace of Death (Che		22,140	es Z 🗆 NO
Vit	nysicia lis cer direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Ir	patient 2 ER/Outpat	ient 3 DOA Oth	ner: 4  Nursing H	lome 5 <b>∑</b> ∕Res	idence 6 Other (Spe	ecify)
on of	nding Ph ath. r: After th	Certificate:	2 Accident Investigation	injury 28b. Time , <i>Day, Year)</i> injury	/ worl	ry at k? ] Yes 2 □ No	28d. Describe	how injury occurred	
Division of Vital	al or Atte s after des al Directo	Certif		f Injury - At home, farm, s g, etc. (Specify)	street, factory, office			(Street and Number or R wn, State)	ural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis only one) 3 Certifying Nurse Practitioner:	of examination and/or inv	estigation, in my opini	on, death occurred	at the time, date	and place, and due to the	e cause(s) and manner stated.
	To the within community of the community		29b. Signature and title of certifier		29c. Licens	54717		29d. Date signed (Mon	
7			30. Name and address of person who completed cause  Rameen Molari, Mo	of death (Item 23a) (Type	Print\	ite 200	Liter	ille Mo 2	1093
h	Sta Registr		31. Date filed (Month, Day, Year) 32. Rec NOV 2 6 2012	10755 F. gistrar's Signature	,				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #4c Per PHY G934 12/06/2012 JH State of Maryland / Department of Health and Mental Hygiene 35802 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2009 201°2 1:05  $A_{M}$ Elizabeth Kirkpatrick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
21204 Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Director 1 M 2 X F 91 216-46-7092 Pennsylvania March 6. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Baltimore Ruxton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 309 Greenwood Rd. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1943 If Yes, Give 10/5 1 Never Mamied 2 Married 2 within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify: Specify: 3 X Widowed 4 Divorced Completed 1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse healthcare 12 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bailey Henry McCormick Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 E. Oak Ave; Moorestown, NJ 08057 Molly Kirkpatrick - daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Societe Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. shook 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ok, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) anom Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events Due to (or as a consequence of): Exami the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be emithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᇫ Completed 1 🗌 Yeş No 3 Probably 4 Unknown 2 . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 0 8 2012 . Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 04, Physician/ 7:05 am Patsy Ogle Campbell Kelley November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Howard New Life Assisted Living If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 6. Sex Min 314-20-4517 Director 1 □ M 2 🛛 F 87 March 09.1925 Indiana Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic avent the action of the staumatic avent. r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8401 Ivy Drive 21043 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Campbell Louise C. Knotts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Ball - Attorney 10306 Eaton Place, Ste. 130, Fairfax, Virginia 22030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Ukn Date 20c. Location - City or Town, State 1 🂢 Burial 2 □ Cremation 3 💢 Removal from State 4 □ Donation 5 □ Other (Specify) Arlington Natl Cem Arlington, Virginia 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee M. tim MOLD 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
7 Years Immediate Cause (Final Physician/ disease or condition resulting in death) End-Stage Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician applyed 2 should be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospitar or within 24 hours after death.

To the Funeral Director: After this certificate is the Funeral director, parametery filled in by the funeral director, par Yes 2 X **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bigcirc$  Other (Specify) Assisted Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D38762 November 05, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Sharon McCormack, 5411 Old Frederick Road, #18, Baltimore, Maryland 31. Date filed (Month, Day, Year) NOV 0 8 2012 32. Register's Signature State

Registrar

DHMH 17 Rev 06-2011

12-08352 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Thomas Kline, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ Decedent's Name (First, Middle, Last) Month Day November 4, 2012 **Medical Examiner** 2002 hrs 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Carroll 533 Baltimore Boulevard Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days oreign Months Director Hours Country) 1 9 M UN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No arrol be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marifal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed is marked other than "nat during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname 17., Father's Name (First, Middle, Last) 8 l and 2 should ို 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date timore, nt of H crematory or other place) Pages 1 1 Burial 2 Cremation 3 Removal from State 06. Donation 5 Other Specify 21. Signature of Funeral Service Licensee 40144 Approximate Interval 23a. Pa 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Hanging Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initialed Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 🗸 No Yes 26.Place of Death (Check only one) 25. Was case referred to medical of Vital 8 Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA 2 ٥ 1 Yes 2 No 28a. Date of Injury FOUND: Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject found hanging Natural FOUND: 1 Yes 2 ✔ No Division Pending the Nov 4, 2012 1958 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗹 Suicide Could not be or Town, State) 533 Baltimore Boulevard, Westminster, MD determined 24 hours a (Specify) Hotel/Motel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 5, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 egistrar's Signatui State Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ 7:45 A M Rosemary Kentfield November 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clayton Comfort Care Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director 552-30-7299 1 □ M 2 🔯 F 91 Yrs Sept.29,1921 Michigan Usual Residence of Deceden in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Briggs Chaney Rd. 20905 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever be Reilly Joseph Catherine K1ebold Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau 1615 Manchester Lane NW, Washington D.C. C. Kevin Kentfield / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 11/06/2012 Beltsville, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD any Inj Signature of Funeral Service Digensee M00382 tiple to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ CARDIAC ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) **E**xaminer ADVANCED AGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physiclan: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Yes 2 🗓 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION, ADVANCED DEMENTIA, Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown HISTORY OF MITRAL REGURGITATION AND 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
1 ☐ Yes 2 ☐ No AORTIC REGURGITATION 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & XXOther (Specify) LIVING 1 ☐ Yes 2 🔀 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

Registrar DHMH 17 Rev 06-2011

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JACOB CHERIAN M.D.

NOVO 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

arks

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D50973

10910 LITTLE PATUXENT PKWY. #105R, COLUMBIA, MD

29d. Date signed (Month, Day, Year)

NOVEMBER 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11/5/2012 Physician/ Marion S. Lynch  $P^{M}$ 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Svkesville Brinton Woods Carroll Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours Min (Month, Day, Year, 090-05-6457 Director 1 □ M 2 🏋 F 100 6/2/1912 New Jersey Usual Residence of Decede item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Sykesville Carrol1 1 Yes 2 X No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 1442 Buckhorn Rd. 21784 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items; any injury or other traumatic percent 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Newspaper 10 Proofreader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Schwinn Mary Gartland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Carroll Highlands Rd., Sykesville, MD 21784 Joe Lynch / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Atlantic Crematory 11/8/2012 Glen Burnie, MD of F eral ervice Licenses 21. Signatur 22. Name and Address of Facility Witzke Funeral Homes, Inc. houll 1 5555 Twin Knolls Rd., Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RILLOU disease or condition Medical resulting in death) Due to (or as a consequance of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death n signed by the at uld be detached fo 2 3 10 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I funeral director, page 2: autopsy performed? Yes 2 N death? 2 🗌 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other 2 HNO 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b.

Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date

signed (Month, Day, Year)

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gwendolyn T. Lynch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital 8. Date of Birth
(Month, Day, Year)
Sept 15, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Davs Months Maryland Director 216-14-7954 92 Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Tes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21207 3628 Forest Garden Ave. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?,
1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Meg Elementary/Secondary (0-12) College (1-4 or 5+) education teacher 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Mae Sampson George B. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Horseman Ct; Foxridge, MD 21133 19a. Informant's Name/Relationship (Type, Print) Thomas L. Lynch - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signature of Fundal Style Licenter Nona I Mrector 655 W. Baltimore St; Baltimore, MD 21201 m Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or teart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Frier Industring Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04265 N 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar era

P O VON

31. Date filed (Month, Day, Year)

5

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 2:30 Рм Michael David Larosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 1 X M 2 🗆 F 220-62-4841 57 Sept 4, 1955 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Edgewood Harford 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? 23a Funeral USA 1941 Edgewater Dr; Apt J 21040 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🂢 No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) county government 0 environmental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie McVickers Ernest Lakosa 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 1941 Edgewater Dr #J; Edgewood, MD 21040 19a. Informant's Name/Relationship (Type, Print) Margaret Larosa - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Qther (Specify) 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph\_sician/ acute gasticintestma probabe Medical resulting in death) e to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to for se's consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Division of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after death To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 1)0017223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 apper Chesageable Dr., Bel tre MD 21014 remin 31. Date filed (Month, Day, Year) registrar's Signature State NOV08 Registrar

92

M 80001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a, pt. II, 27, 28a-f, per me, 2940 6-19-13 sm.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month lictoria 2013 0630 me Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shock Trauma Certer Baltimon. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) unk (Month, Day, Year) Hours **Director** 275-56-3638 1 □ M 2 🗓 F 60 Feb 19, 1952 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No MD Baltimore 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21223 742 Linnard St. death v 12. Was Decedent Ever in U.S. Armed Forces? unk
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. unk 11. Marital Status Black, White, etc 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify. "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) unk Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk William Dunbar - friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) In state 21. Signate e o Ronald 22. Name and Address of Facility State Anatomy Board S. Wale, Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it say leading to immediate cause. Enter Underlying Examiner Premoria Vacti Intertion Cause (Disease or injury burial-tran and that initiated events resulting in death) Last ATKAN AND ROVED BY MEDICAL EXAMPLER attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregna 23d. Date of delivery in the past 12 month Month Year Day detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to by Acute Respiratory Distress 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Right Hip Fracture 24a. Was an performed' Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examined?
1 ✓ Yes 2 ◯ No Be 26. Place of Death (Check only one) Hospital Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manne Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 5 Pending subject fell after death. 2 X No 2 X Accident fd:9-25-12 unk Investigation 6 Could not be ☐ Suicide ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) **/42 Linnard** St. filled in by determined Baltimore, MD. Home 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor

To the Fune

completely fi Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifig 20 completed cause of death (Item 23a) (Type, Print) 30. Name and addre

Registrar DHMH 17 Rev 06-2011

State

James

Lastn 31. Date filed (Month, Day, Year)

NOV08

Shock

bama Certer

22 S Grune St

Bultimore

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of	Maryland / Depa			1ental Hyg	iene	
		_	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eath		eg. No. 2	2 35814
	Physicia	n/	Ann Lemerise				2. Date of Deatl	16, 2012	3. Time of Death 3:28 AMM
-	Medic Examin		4a. Facility Name (if not institution, give street and numb	er)	4b. City, Town, or L	ocation of Death	occober	4c. County of De	
200	<b>-</b>	-	18 Breezy Court #C		Cockeys			Baltin	
	Funeral			. Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		irthplace (State or Foreign country)
	Director		557-04-0804 1 □XM 2 □ F Usual Residence of Decedent	59 Yrs.	,		July 8,		New York
	and Show	or	10a. State 10b. County	10c. City, Town or Loc	cation		1001/ 01	<u> </u>	10d. Inside City Limits
	Maryla 28a-f otifiec	Director	MD Baltimore	Cockeys	ville				1 ☐ Yes 2 ☐ No
	h the	al Di	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	Country?
	th with ms 23 must	Funeral	18 Breezy Court #C		21030	1 0110/0	- N		
·^	r dea or itel		11. Marital Status 12. Was Deced Armed Force 1   Never Married 2 □ Married 1 □ Yes	es2,- If	Vas Decedent of Hisp Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh	
93	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced If Yes, Give Year or Dat	1	Yes 2 No	Specify:		Specify:	
5-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupat	ion ring most of worki	ing	16b. Kind of Busines	s/Industry
12	thin 7	Som	Elementary/Secondary (0-12) College (1-4	or 5+) life. DO	o NOT use retired) ial worke:			healthc	are
g 5	led wi Hygid other ent, t	Be (	17. Father's Name (First, Middle, Last)	4   500		18. Mother's Name	e (First, Middle, M		
Maryland 21215-0036	should be filed and mand Mental Hydra is marked oth raumatic event.	To	Joseph Edgar Beauregard	II		Doroth	y France	s Schmidt	
ary	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street an	d Number or Rura	l Route Number,	City or Town State, 2 D 21208	Zip Code)
	and 2 s Health em 27 ther tra		Christine Higgins - fr						
mor	Page 1 annent of Hant of Hant of Hant of Hant of Hant or of		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from \$ 4 □ Donation 5 ☒ Other (Specify) in stat	tato	sition (Name of natory or other place)	,	Date	20c. Location - City o	or Iown, State
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur Funeral Service Livense		. Name and Address	of Facility Sta	te Anato	my Board timore, M	D 21201
	E0 = 00		23a. Part 1. Enter the disease, or complications that ca						Approximate
≯as I	Ph_sician/		shock, or Neart failure. List only one cause on eac Immediate Cause (Final	n line.	/			,	Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (o	r as a consequence of):	1766110	C 107	5 2015	4	1/22.
A.	Examiner	<u>.</u>	Sequentially list conditions, b.						
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):					
	kecute n and al-tran	Exal	that initiated events c.	r as a consequence of):					
09	s be e /siciar e buri	dical	d						
9/89	tificate ng phy	Med	IF FEMALE:						
9 X	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant   23c. If yes, outcome in the past 12 months?   1 \int Live B	ome of pregnancy irth 2  Fetal death 3				23d. Date of o	delivery Day Year
P.O. Box	ne dea r the a	ysic	1 Yes 2 No 4 Pregn. 9 Unknown		Other (specify)				
O.	that th	y Pł	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	quires en sign ould by	ted t	Montid ohisik	1			1 🗆 Ye	es 2 No 3 🗆	Probably 4 \( \sum \) Unknown
COL	aw rec as be	ple					24a. Was ar autops	y prior to	autopsy findings available o completion of cause of
Division of Vital Records,	The la	Con					perform	ned? death?	? 'es 2 🗆 No
ta	ician: certifii rector	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Other	e of Death (Check			
> <u>&gt;</u>	Phys rr this eral di	e: To	27. Manner of Death 28a. Date o	patient 2 ER/Outpatien injury 28b. Time of	t 3 DOA 28c. Injury a	4 L Nursing Ho		ence 6 Other (Spe w injury occurred	ecify)
UC C	nding ath. r: Afte	icat	Natural 5 Pending (Month	, Day, Year) injury	work?	es 2 🗆 No		····,-·· <b>,</b>	
/ISIC	r Atte ter des recto	Certificate:		f Injury - At home, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Number or F	Rural Route Number,
	oital o urs af ral Di								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:	st of my knowledge, death o of examination and/or invest To the best of my knowledge.	igation, in my opinion, death occurred at the	date and place, at , death occurred at e time, date and pla	nd due to the cau the time, date and ace, and due to the	ise(s) and manner as d place, and due to the e cause(s) and manner	stated. e cause(s) and manner stated. r as stated.
	To the within To the comp	2	29b. Signature and title of certifier	and the state of t	29c. License r	number	2	9d. Date signed (Mor	nth, Day, Year)
			Jour 2, Shery	V	Dol	442		Det. ber	20,2012
			30. Name and address of person who completed cause	of death (Item 23a) (Type, P	rint)	·, St-7	11 13.	1 to md	21204
	Stat	e.	31. Date filed (Month, Day, Year) 32. Re NOV 0 8 2012	gistrar's Signature	1	2			e cause(s) and manner stated. r as stated. nth, Day, Year) 20, 2012 ZIZ04
	Registra	ar	MAN A O CAIL CAMP	Jr. Jagara					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month i Day Physician/ 0,5 WOUVE 0260AM Ran dall WAVERDE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ValROII tonzoil WO Hespital (Contr) West minster2 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 212-42-1333 1 🗆 M 2 💢 F **Director** 69 MD 001 21 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f Carroll 1 X Yes 2 No MD Westminster 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ar than "natural", or items 23a or the Medical Examiner must be r Funeral 102 Timber Ridge Dr., Apt. 207 21157 USA and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Aide Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daniel G. Randall Irene Narowanski other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mary Ann Nipper-daughter 309 Crestview Ct., Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/6/2012 Westminster, MD Central MD Crem uneral Service Licer 22. Name and Address of Facility Fletcher Funeral & Cremation Main St., Westminster, MD 21157 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ 11/02 tuiluge disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner vanual 0000 Sequentially list conditions cause. Enter Underlying Exami use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760<sup><</sup> yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 5 Other (specify) Month Day Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by (Janua/2 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an JORONARY page 2 s autopsy Mypartinsio mauris After this certificate 2 No 1 Yes 25. Was case ferred to medical examiner? Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 🗌 Yes ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA tely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a edical 29a. Certifier ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

State Registrar 31. Date filed (Month, Day, Year, NOVO

Signature and title of certifie

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) MEMORIAL 32. Registrar's Signature

Dosna D. B. Kalyan

29c. License numbe

D 62362

AVANUO , WIST MISTIR

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01.10AM RAI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Months Min. (Month, Day, Year) 215-34-8210 74 Director 1 M 2 1938 Maryland Nov. 1. Usual Residence of Decedent should be filed within 72 inverses and Mental Hygiene.
7 is marked other than "ratural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Severna Park Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 573 Richard Wav 21146 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify f Yes, Give Year or Dates 3 XWidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Ft. Howard Paper Co. N/A Bookkeeper injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Meni Important: If Item 27 is marke any injury or other traumatic Gladys Elliott Vetters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 452 Bendale Drive Severna Park, Maryland 21146 Tracy M. Payer (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atlantic Cremation 11/08/2012 4 Donation 5 Other (Specify) |Glen Burnie, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee MOO-732 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Examine Due to (or as a consequence of) attending physician and if for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be de 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Tyes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 in the funeral director, page 2. autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1100 မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 - Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospitai Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 ss of person who completed cause of death (Item 23a) (Type, Print) 30 Name and addre DEFFNSE OR NEVIEUE 31. Date filed (Month, Day, Year) State NOV O 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ATRIUM VILLAGE OWINGS MILLS Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days 220-74-1864 1 □ M 2 🗓 F Director 01/10/1912 MD 100 filed within 72 hours and tall Hygiene.

All Hygiene.

ed other than "naturel", or items 23e or 28e-f show ed other than "naturel", or items 23e or 28e-f show event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 - Yes 2 1 No BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? Funeral 21117 4730 ATRIUM COURT, #649 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be filk h end Mental I 7 is marked o HYMAN SPEERT **JENNY** Department of Health enc Importent: If item 27 is rr. eny injury or other traume once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WALTER MILLER/SON 11213 BROAD GREEN DRIVE, POTOMAC, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ARLINGTON CHIZUK AMUNO CEMETERY 1 XBurial 2 Cremation 3 Removal from State 11/07/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign Ture of Tuneral Service Lipenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neu disease or condition resulting in death) MO w Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir signed by the attending physician end d be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed After this certificate has been strunged the strunged of the s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 🗌 No 1 Yes rs after deam. ral Director: After this cerumonal by the funeral director, pr 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident Investigation 3 \subsection Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m and address of person who completed cause of death (Item 23a) (Type, Print) BOB

State Registrar 31. Date filed (Month, Day, Year)

NOV 0

DHMH 17 Rev 06-2011

				Pleas	e Type or	Print in	Black Ir	ndelib	le Ini	k. Ens	ure A	II Copie	s Are	e Legi	ble.		
		-	For		State	of Maryla	nd / Depa				and M	lental Hy	giene	Э			
			<ul><li>State Registrar</li></ul>				Cer	tificat	e of L	Death			Reg. N	0. 20	12	35	811
ı	Physicia Medic		1. Decedent's Name Bernard			v. Sr.			_			2. Date of De Month Novem		ay , ,	Year	3. Time of 7'. (C)	
1	Examin		4a. Facility Name (if n				2			Location	of Death		40	C. County			
			SHINT )						r 1 Year		24 Hrs	8. Date of Bi	rth	BALT	-		r Fornian
	Director	212-22-5422  1 🖾 M 2 🗆 F  88 Yrs. Months Days Ho				Hours	Min.	3/1/192	ay, Year)		9. Birthplace (State or Foreign Country) Maryland		rroragir				
	show	ō		10b. County		10c. C	City, Town or Lo	cation							1	0d. Inside Cit	ty Limits
	Mary 28a-f	≐		Baltimo	ore	Ti	monium									1 🗌 Yes	2 🙀 No
	s 23e or	Funeral D	10e. Street and Numb 221 Deep		rive				093	_				S.A.	hat Cour	ntry?	
9036	within 72 hours aftar daath with the Maryland Jiana. In than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at	ed by Fur	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		Armed F	2 ☐ No ve	1	f Yes, spe	cify Cuba		n, Puerto	cify Yes or No Rican, etc.)	-		k, White,		
Baltimore, Maryland 21215-0036	in 72 hou a. kan "natu Medica	Completed by	(Special Special Speci		grade completed	1) 1-4 or 5+)			ork done o	during mos	at of worki	ing	16b. l	Kind of Bu	siness/In	dustry	
2	led within Hygiana. other thar	0	12			·	Upho]	<u>ster</u>	er	<u></u>		-		-	~	olster	·ey
and and	ild be filed w Mantel Hyg harkad othe hatic event,	면 일	17. Father's Name (Fi		•							e (First, Middle	, Maider	n Surname)	)		
چ	ould bid Maid Maid Maid Maid Maid Maid Maid Ma		George M				10h Maili	a Addros	e (Street		ce F	OX Il Route Numb	or City o	or Town St	ate Zin (	Codel	
<b>∑</b>	12 should alth end halth end halth trains		Dorothy			ife						monium.					
ē,	E E E		20a. Method of Dispo			20b	. Place of Dispo cemetery, crei	sition (Na	me of	cal	1	Date	20c. I	Location -	City or To	own, State	
Ē	Paga nant c ant: if		1 ☐ Burial 2 ☐ 4 ☐ Donation	J Cremation 3 5 ☑ Other (Spe	I□ Removal from ecify) Entom	oment D	ulaney				11/6	/2012	Tir	noniu	m, M	lary1ar	nd
ä	parmit. Paga 1 a Dapertmant of h important: if ite eny injury or ot		21. Sign full of Euro	al Service LIC	ensee ///	/-						k Towso					ic.
<u> </u>	20.5 29		NIO CAL	M/ (	11/11/0	n				Road		son, Ma		and 2	1204		
ا ا	Medical Examiner	13/55	23a. Part 1. Enfer the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List onli inal	ly one cause on e	each line.	14IC 5T			ig, sucii as	cardiac	n respiratory a	irest,			Approximat Interval Bet Onset and I	ween
	LXammer	-6	Sequentially list conditions.				YPERTENSION  to for an a connection of the										
	ad sit	Examine	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying  Cause (Disease or injury														
	ta ba axecutad nysician and ha buriel-transit	اتها															
. Box 68760	Attending Physician: The law requires that the death cartificate be riched. After this cartificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the but the funeral director, page 2.	Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							су				23d. Dat Mor		•	Year
s, P.O.	res that the signed by d ba data	þ								e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknow			,				
cord	ilaw raquire has baan si ya 2 should I	Completed										24a. Wa	opsy	Р	Vere auto prior to co leath?	psy findings a	available cause of
æ	: Tha icata l r, pagi		<u> </u>		-							1 ☐ Yes	formed?		Yes	2 🗆 No	
ital	sician cartif irecto	Be	25. Was case referred examiner?  1  Yes 2		Hospital:	7			Oth	lace of Dea	'			. [7]			_
<u>}</u>	Physical dispersion of the second dispersion o	은 ::	27. Manner of Death		28a. Date	e of injury	ER/Outpatie 28b. Time o		28c. Injur	ry at	lursing Ho	ome 5 Res 28d. Describe				<i>/</i> )	
Division of Vital Records,	To the Hospital or Attending Physician: Tha la within 24 hours after dash. To the Funeral Diractor: After this cartificate he completely filled in by the funeral director, page	Certificate:	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined Investigation 1 № None (Month, Day, Year) injury injury with the second of the					M 1 ☐ Yes 2 ☐ No				er or Rura	l Route Numl	ber,			
۵	the Hospital or / thin 24 hours aftar the Funeral Dira mplataly fillad in k	Medical	(Check 2	☐ Medical Ex	Physician: To the aminer: On the balance Practition	asis of examinat	tion and/or inves	tigation, ir	n my opini	ion, death o	occurred a	t the time, date	and plac	ce, and due	to the ca	iuse(s) and ma	anner stated
	Vithi Com		29b. Signature and ti	tle of certifier	1	_		29		e number			/	ate signed			
			<b>P</b>	11	//				DH	635	6		NO	ven	be	(3, 2)	2012
	HYLV		30. Name and addres	/			em 23a) (Type,		0 0	OTILE	Total	15001	ΔA F	5 2 1	20	ч	
	Sta	l te	31. Date filed (Month			egistrar's Sign		<b>プレビ</b>	14 17	MAR	100	, , , , ,	IVI	~ ^ `	~ ~		
	Registr		A	INV O R	2012		1 1	0.00	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b, perFH, G933, 11716/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pearl 0xorn Mades 2012 November 2:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Director 128-18-1827 1 [] M 2 [X] F 86 Vrs Oct. 17,1926 New York Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Madical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Maryland Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3124 Gracefield Rd. #105 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2XX Married Completed by Maryland 21215-0036 1 Yes 2XX No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Instructor Education t. Page 1 and 2 should be filed with tment of Heelth end Mental Hygier rtent: If item 27 is marked other t jury or other traumatic event, Ib Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samue1 Hersh Futterman Ida Pear1man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3124 Gracefield Rd. #105, Silver Spring, MD 20904 Pearl Oxorn Mades / Self Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c Location - City or Town State cemetery, crematory or other place)
Cedar Park Cemetery 19,201 1 X Burial 2 Cremation 3 Removal from State Nov. Emerson permit. Page Department c Importent: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) (unk) Paramus. 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Signature of Fune M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): <sup>r</sup>Examiner PERITONISTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): PERFORATED DUODENAL ULCER Hospital or Attending Physician: The lew requires that the death certificate be executed the burial-trar that initiated ever Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2X 9 Unknown filled in by the funeral director, page 2 should be deteched 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CLOSTRIDIUM DIFFICULI COLITIS 1 🗌 Yes 2XXNo 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2XXNo 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Use Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number achille D44156 Alexion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Alexion 3110 Gracefie MD

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month,

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month KOSA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death acueral COWNERIA HOW If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 256.82 **Director** 1 🗆 M 2 🗹 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Erminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No amb 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: If Yes, Give 3. ₩idowed 4 Divorced Completed Year or Dates a 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sugname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) \( \) \( \) \( \) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Crémation 3 Removal from State  $\mathcal{S}_{\cdot}$ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4021280 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner acute Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury Diay to for as a consequence of To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sired director, page 2 should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy refformed? Yes 2 ☐ No death? 1 Yes Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} ဂ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident  $5 \square$  Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge. commed at the time, date and place, and due to the cause(s) and manner as state. 29b. Signature and title of certifi 56 and address of person who completed cause of death (Item 23a) (Type, Print) AZARHAN Cedar

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23. 9:30 PM October 2012 Bell Maguire Marion Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll North Pine Assisted Living Manchester If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 218-03-6037 1 □ M 2 🗓 F 92 Oct. 17, 1920 Maryland show 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ should be filed within 72 hours after death with the Maryland Director or 28a-f sh notified 1 Yes 2 No Carroll Manchester Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 3316 Wilhelm Lane 21102 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status "natural", or iten edical Examiner Black White etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🏖 No 3 X Widowed 4 Divorced Year or Dates er than "nature, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Flementary/Secondary (0-12) and Mental Hygiene. 12th N/A Own Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the once. marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Plitt Teresa Percival Bell 19a. Informant's Name/Relationship (Type, Print) thent of Health and trant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Lindenberg 1508 Kaseys Lakeview Dr., Moneta, VA 25121 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XXIII 2 Cremation 3 Removal from State Nov. 5,2012 Baltimore, Maryland New Cathedral Cem. 4 Donation 5 Other (Specify) 21. Si atur Fundal Service Licensee 22. Name and Address of Facility MBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. allen Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for L Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy performe 2 🗌 No certificate 1 Tes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

NOV 0 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

Stephen Laiken, MD D0022517

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number 0 - 00 2 2 5 1 7

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death ent's Name (First, Middle Last Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE NORTHWEST RANDALLSTOWN Birthpia Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea 217-70-1678 55 1**X** M 2 □ F Director 06-08-1958 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 Is marked other than "natural", or items 23a or 28a-f show purce, injury or other treumatic event, the Medical Examinar and 200.000. 10d. Inside City Limits 10b. Count 10c. City. Town or Location Director 1X Yes 2 No BALTIMORE MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21223 300 N. MONROE STREET 12. Was Decedent Ever in U.S. Armed Forces 7 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 👿 No Specify: BLACK 3 Widowed 4 XDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) TRANSPORTATION DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DOROTHY CROWDER ALEXANDER MC CORMICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3476 DOLFIELD AVE., BALTIMORE, MD 21215 /DAUGHTER CHRISSY MCCORMICK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATION 11/09/12 BALTO., MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 mes Part 1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ mon Medical resulting in death) Due to Examiner y y man Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of) Physician/Medical Hospital or Attending Physicien: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) be detached g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed been si should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? hes this certificate 2 No 1 Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence MUSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t (Month, Day, Year) Hatural 5 Pending Accident 1 Yes 2 No within 24 hours after death
To the Funerel Director: A
completely filled in by the f Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minimal as a stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ed cause of death (Item 23a) (Type, Pri 69 Arc CO) 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 0600 A M Newman Month ctor **Physician** NOV 03 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brighton Gardens Assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 3, 1919 Birthplace (State or Foreign Country) Social Cecurity Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 <del>∏</del> M 2 □ F 052-14-3830 92 New York **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Modeal Examinar must be notified at 1 ☐ Yes 2√ No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7110 Minstrel Way, Apt 213 21045 Funeral 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ∏Yes 2 Yes, Give 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2**X** No þ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmacology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental is ant: If item 27 is marked o Morris Newman Betty Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia Dresner-daughter 121 Otis Dr., Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department o Important: If any injury or <u>~</u> 5 Beth Moses Cemetery Nov. 5,2012 Pinelawn, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, Maryland 21045 MOIZZY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death
30 Years disease Immediate Cause (Final Bronary Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any latest conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) O, Box 68760, physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year for Month 5 Other (specify) ☐Yes 2☐No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Congestive Heart 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 2**X**1No 1 □Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? 34:5te6 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 56531 Nov 3rd 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li Sbeo Snowden River pkwy, #301, columbia, mD21045 OV 8600 Snowden

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 7:26 Рм O'Brien Geraldine Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Pasadena 321 Cambridge Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday **Funeral** Days Hours 1 □ M 2 🗓 F Director 212-26-2755 Yrs July 23, 1927 | Maryland 85 Usual Residence of Decedent 10d. Inside City Limits f Heaith and Mentel Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28a-f show other treumetic event, the Medical Examiner must be retified at 10c. City, Town or Location 10b. County 10a. State be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Pasadena Anne Arundel Marvland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21122 321 Cambridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates 3 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ရ Stoner Cora Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 Cambridge Road Pasadena, Maryland 21122 Charles J. O'Brien (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportent: If ite
eny Injury or ot 1 XBurial 2 Cremation 3 Removal from State Brooklyn Park, Maryland 11/10/2012 Cedar Hill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MOD-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 231 Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER onths Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physiclan/Medical P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo Day Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Tyes 2 X 26. Place of Death (Check only one) Division of Vital Be ( 25. Was case referred to medical examiner? 1 ☐ Yes 2 🗡 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation
6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOVEMBER 7th 2012 Donna

Registrar

DHMH 17 Rev 06-2011

State

0

204

GLEN BURNIE

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OAKWOOD

NOV 0

31. Date filed (Month, Day, Year)

RD

SVITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:50 AM November 201 Levi Edison Oliver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5318 Philippi Ave. Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jul 01, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days Months Hours Min. 71 1941 Director 213-62-7176 Usual Residence of Decedent Itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location death with the Maryland Director 1. Yes 2 ☐ No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21206 Trinadad 5318 Philippi Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. permit, Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglana. Important: If Itam 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examination 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 21215-(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employeed Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Oliver Doris Lynch Leo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4305 Mary Ave. Baltimore, MD 21206 Stephanie Oliver /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 03 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Chesapeake Crematory 22. Name and Address of Facility Signature of Funeral Service Licensee Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificate ba axacutad within 24 hours after death.

To the Funeral Director: After this cartificata has baan signad by tha attanding physician and complataly filled in by tha funaral director, paga 2 should ba detached for usa as tha burlal-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death ☐Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accide 5 Pending 1 Tes 2 No Accident Investigation Suicide Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of death (Item 23a) (Type, Print) State Registrar

,50ar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death 2012 1836 November 4, William Harvey Page 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carrol1 Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Ye Nov. 10, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1**⊠** M 2□ F Maryland 80 218-28-2256 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No MD Carrol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21158 1392 Alison Court Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖾 No 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Comcast Warehouse Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Huston Harvey Page 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1392 Alison Court; Westminster, MD 21158 Patricia McDonald-Step Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 11/7/2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. 21. Signature of Furieral Der ce Licensee MOIOSU MD 21228 1630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ರ Acute Muccardia Due to (or as a consequence f) ANASCI Sequentially list conditions

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

≥

Completed

Be

ဥ

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madral Examir exmust be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Registrar

29b. Signature and title of certifie

30. Name and address of p

dical Examin	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. COPD-1=mphyseme  Due to (or as a consequence of):  d. Recurrent Small Cell	CA-Luny Few Mant
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
ò	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in P	23e. Did tobacco use contribute to the cause of death?  Yes 2 \bigcap No 3 \bigcap Probably 4 \bigcap Unknown
Completed			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No
Be	25. Was case referred to medical	26. F	Place of Death (Check only one)
10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
ation: T	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred 2 □ No
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
dical C		yeician: To the best of my knowledge death occurred at the time, da niner: On the basis of examination and/or investigation, in my opinion, and/nanner stated.	

29c. License number

D37949

29d. Date signed (Month, Day, Year)

Nov. 5th 2012

(Item 23a) (Type, Print)

ted cause of dea

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Month $P_{M}$ PEARSON 18 ZEROME SPENCER SI 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SILVER MONTGOMERY CROSS HOSPIERI SPRING Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 1 M 2 D F 9 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits P.Co. 1 Ves 2 No AUREI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9105 20708 BRIVARCHIP SM 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) M NA W 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PEARSON SPENCER SHERBLLE CREENE BUMBNIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITA 1200 FOREST GLEN 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state Signature of Funeral Service Lich Three Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death PREMIATURE RUPTURE disease or condition resulting in death) FETAL MEMBRANES Due to (or as a consequence of): RUICIAL MCOMPET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical **Examiner** 

and

attending physician for use as the buria

signed by the a d be detached f

has

s after death

I Director: A

d in by the f

within 24 hours aft

To the Funeral Di

completely filled in

Medical

certificate be Box 68760

P.0.

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death

Department of Important: If it any injury or o

Physician/

Medical

10a. State

Director

Funeral

þ

Completed

Be

ပ္

Examiner

**Funeral** 

Director

28a-f shov aţ

ō

23a

ō

"natural",

Il Hygiene. other than "

and Mental Fishers is marked of

ige 1 and 2 should be nt of Health and Men :: If item 27 is marke

death

within 72 hours after

Maryland 21215-0036

Saltimore,

must be notified

Examiner

the Medical

traumatic event,

as nse Certificate:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical

examiner?

27. Manner of Death

1 Matural

Accident

Suicide

4 Homicide

29a. Certifier

2 No

5 Pending

Investigation

6 Could not be

ũ Physician/Medical by Completed Be မ

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

28a. Date of injury (Month, Day, Year)

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

Pregnant at time of death 9 Unknown

Ectopic pregnancy Other (specify)

23d. Date of delivery Month Day

Year

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 🗌 No

2	26. Place of Death (Check only one)								
AC	Other: 4  Nursing H	ome	5 Residence	6 ☐ Other (Specify)					
			Describe how inj						

1 Minpatient 2 ER/Outpatient 3 D work?
1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Preptitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

ANGELA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifi

NOV 0

6 WATKINS MILL

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Las 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2403 Mosher Street Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Director 212-12-1532 1 M 2 V F 94 May 20, 1918 Maryland Usual Residence of Decedent filed within 72 hours efter deeth with the Merylend el Hygiene. dother than "naturel", or items 23e or 28e-f show event, the Medical Examiner must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2403 Mosher Street 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc \$ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 Ulidowed 4 Divorced Specify: black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) housewife own home Be permit. Pege 1 and 2 should be filed Department of Heelth and Mentei Hy Important: If Item 27 is marked oth eny injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Augustine Brown Sarah Jane Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2403 Mosher Street Baltimore, MD 21216 Vernon Press/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ∑ Donation 5 ☐ Other (Specify) Ronald S Wad Signat 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Polycy ThemiA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burlal-transit To the Hospital or Attending Physicien: The lew requires thet the deeth certificete be executed Due to (or as a consequence of): resulting in death) Last ettending physician for use as the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) be detached the 9 Unknown 9 Unknown Division of Vital Records, P.O. sete hes been signed by to page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS Kajapahl MD D0057465 10/26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lalimore MD 21209 5703

Registrar

State

SMIM

2835

NSKAJAPAKSEND

U 8

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,16a&b,17,18&19a&b, Per AN BD C933,11,729/2012 JH State of Maryland Department of Health and Mental Hygiene/2012 JH

		•	_ State	ate of Maryland	•	artment of H tificate of D		na Memai	, 0	001	0 0 0 0 0 0 5
			Registrar  1. Decedent's Name (First, Middle, Last)		001	uncate of L	Calli	2. Date	Reg. of Death	No.	3. Time of Death
	Physicia Medic		THOMAS PER					Mon	1, 2	Day Year	
	Examin	er	4a. Facility Name (if not institution, give street	ŕ		4b. City, Town, or		-	, .	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	If Under 24	SPICIN Hrs. 8. Date			irthplace (State or Foreign
	Director		223-70-3278 1MM:		Yrs.	Months Days		Min. (Mon	th, Day, Yea	(r) C	country)
	d d	_	Usual Residence of Decedent  10a. State 10b. County	1100 670	Town or Lo	ation		10,	28,10	341 N	ew York
	arylan a-fsh fied :	ecto		1	Town or Lo		. 1 6				10d. Inside City Limits 1
	or 28	Dire	MD MONTGO  10e. Street and Number	MERCY SI	COR	R SPRI 10f. Zip Code	00		10a.	Citizen of What C	
	s 23a	Funeral Director	10111 MCKEN	NEY A	VR	1209	02		Ĭ		
	death 'itam	F	Ar	as Decedent Ever in U.S. med Forces?	13. \	Vas Decedent of His Yes, specify Cubar	spanic Origin	n? (Specify Yes o	or No-	14. Race - Am Black, Whi	
38	after al", or	Completed by	1 Never Married 2 Married  3 Widowed 4X Divorced	Yes 2 No Yes, Give No ar or Dates.	- 1	☐ Yes 2 No			,	Specify:	ite, etc.
21215-0036	hours natur	lete	15. Decedent's Educatio	1	16a. Deced	ent's Usual Occupa	ition unk	ŧ	16b	. Kind of Busines	s/Industry Unik
215	nin 72 na. <b>'han</b> "	mo J	(Specify only highest grade con Elementary/Secondary (0-12)	llege (1-4 or 5+)	life. D	ind of work done d O NOT use retired)	-	f working			
2	d with Hygier than t	ادها	17. Father's Name (First, Middle, Last) unk	unk	Cosm	etologist	_			smetolog	1
auc	be fila ental P kad o kad o	일	Herman Wesley Pears					s Name (First, M othy Loi		en Surname) <del>UN</del> Davie	- C
ary	nd M		19a. Informant's Name (Relationship (Type Strip		19b-Mailic	a Address (Street €					Zib Coope) <del>50,410</del>
Σ	nd 2 sl salth s n 27 i		HOLY CROSS +	1977AS	+ <del>50</del>	3 80x 2401	: Unes	ster, VA	23031	SILVER	CH SUINTS
Baltimore, Maryland	permit. Page 1 and 2 should be filad within 72 hours after death with tha Maryland Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natural", or itams 23a or 28a-f show eny injury or other traumatic avant, the Medical Evanimen must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove			sition (Name of natory or other place	e)	Date	20c	. Location - City o	or Town, State
Ħ.	t. Pag rtman rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)	in state							
Ba	Depa Impo eny il		21. Signatur of Francis Service Licensee Ron Tu Sy	e Director	22	Name and Addres					21201
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	is that caused the death. e on each line.	Do not ente	r the mode of dying	, such as ca	rdiac or respirat	ory arrest,		Approximate Interval Between
	nysician/	i a		ESPIRAT		PAI	UR	8			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):		8	0 2 0	C E		
		ner	Sequentially list conditions, b.	oue to (or as a conseque	rice oi).	MNG		264	25		
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	·							
	icate be executed physician and is the burlai-transit	al E	resulting in death) Last	Due to (or as a conseque	nce of):						
760	cate b	edical	d								
98	certifi inding use a		IF FEMALE: 23b. Was decedent pregnant 23c. If )	es, outcome of pregnanc	су	1				23d. Date of d	elivery
Box	death ne atte ed for	sicia	1 Yes 2 No	☐ Live Birth 2 ☐ Fetal o ☐ Pregnant at time of dea ☐ Unknown		Other (specify)	/			Month	Day Year
0	at the d by tl detach	F.	9 ☐ Unknown  Part II. Other significant conditions contribut		ting in the u	nderlying cause give	en in Part I	220	Did tobooo	o uno pontributo t	to the cause of death?
Division of Vital Records, P.O. Box 68	lres th signa Id be o	Completed by Physician/N	LARYNGEAL	CANCER	_	asilying vacco give		236.			Probably 4 🗹 Unknown
o G	w requ	plete	SEVERE MALNI	ADITION	S			24a.	Was an	24b. Were a	utopsy findings available
Rec	Tha la ate ha page ?	E						_	autopsy performed Yes 2 1	? death?	es 2 No
ta	clan: artific ector,		25. Was case referred to medical examiner?					(Check only one			
<u> </u>	Physi this o ral dir	2	1 ☐ Yes 2 ☐ No Hospita  27. Manner of Death 28;	1 Malinpatient 2 ☐ El	R/Outpatien		4 LJ Nursi			6 ☐ Other (Spe	ecify)
0	ding th.	cate	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🗆	at Yes 2.⊡No	- 1	ribe how in	jury occurred	
isio	Attar er dea ector by th	Certificate:	3 Suicide 6 Could not be	. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre			28f. Loca			ural Route Number,
<u> </u>	ital or urs aft rai Dir illad in								or Town, Sta		
	To the Hospital or Attanding Physician: The law requires that the death certifing the hours affard ceath.  within 24 hours affard ceath.  To the Funcal Director. After this cartificate has baen signad by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier (Check Check Only one) 1 Certifying Physician: 7 Certifying Physician: 7 Certifying Physician: 7 Certifying Nurse Pract	the basis of examination a	and/or invest	gation, in my opinior	n, death occu	rred at the time.	date and pla	ice, and due to the	cause(s) and manner stated.
_	with con the contract t		29b. Signature and title of certifier	M	<u></u>	29c. License	number			Date signed (Mon	
		-	M			D63	343	>	110	1,291:	2012
			30. Name and address of person who complete				241 0	500	200	n 000	10
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re .	EST OL	-EN K	w, 3.	2. 14	D- 700	(( )
	Registra		NOV 0 8 2012	Den &	. de a	Mal					

12-07640

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

effery Arnold P	feiff	er State 1- For State Registrar	of Maryland / De	partment d <i>ertificate</i> d			Menta	al Hy		g. No.	<u> </u>	
Physicia		1. Decedent's Name (First, Middle,La	st)					2	. Date of Death Month		Year	3. Time of Death
/ledical Exami	ner	Jeffrey Arnold Pt 4a. Facility Name (if not institution, gi	feiffer		1 41 0	. +			October 9,	2012		1045 hrs
		60 Glen Ridge Road Apt.				ity, Town, or L len Burnie	ocation of	Death			County of Death nne Arundel	
Funeral	-	5. Social Security Number ank 6. S	_	s. last birthday)		Under 1 Year	If Under	24Hrs.	8. Date of Birth			thplace (State or UNK
Director			XM 2□F 62	Y	rs. M	onths Days	Hours	Min.	March		Fosois	
		Usual Residence of Decedent										
w any		10a. State 10b. County		City, Town or Loc								10d. Inside City Limits
Aaryland 28a-f show I at once.	tor		Arundel	Glen Bu								1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 60 Glen Ridge l	Rd #B3		101	Zip Code 21061			10	g. Citiz US.	en of What Cour A	ntry?
h with	era	11. Marital Status unk	12. Was Decedent Ever in Armed Forces? unk			cedent of Hisp pecify Cuban,			cify Yes or No-	1	14. Race - Ameri White, etc.	can Indian, Black,
or it	Fune	1 Never Married 2 Married	1 Yes 2 No		_			de lo IV	ican, etc.)			
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	þ	Widowed 4 Divorced     Divorced     Specify of the state of the s	If Yes, Give Year or Dates:	1 16a Decede		2 X No		nd of wo	k done 1110 k		Specify: Will nd of Business/I	nite
2 hou	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)			f working life. [				100. KI	nd or businessi	industry unix
036 ithin 7 ne.	Completed	unk	unk									
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last	unk			18	3.Mother's	Name (F	irst, Middle, M	aiden S	Gurname) un	ζ
TOVE, MD 2121, ages 1 and 2 should be fint of Health and Mental 1: If item 27 is marked other traumatic event,	Be	19a. Informant's Name/Relationship (	France Defeat )	1405-14-11								
MD 2 id 2 shoul lith and M m 27 is m sum attic	위	O.C.M.E.	Type, Print )							_	or Town, State, e, MD 23	
and 2 and 2 Lealth trem 2		20a. Method of Disposition	20	b. Place of Dispo							ocation - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 Burial 2 Cremation 3		crematory or o	ther pl	ace)						
nit. P. artme artme		4 Donation 5 Other Specify 21. Sign to 4 of Funeral Stryice Live	the 1	22.	Name	and Address o	of Facility	Stai	te Anat	omv	Foard	
Balti permit. Departr Import injury		voice Mil	Wade, Direct	or						_	ore, MD	21201
Physician		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	olications that caused the dea	ath. Do not enter	the mo	ode of dying, su	uch as car	diac or re	espiratory arres	st, shoc	k, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a.	Hypertensive	Atheros	c1e	rotic (	Cardi	ovas	cular l	Dise	ease	Death
,		or condition resulting in death)	Due to (or as a consequence	e of):								
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.	D									
d d ansit		events resulting in death) Last d.	Due to (or as a consequence	e or).								
O,  be executed sician and ourial - transi	edical	X UNPENDED	AMENDED 23a, pt.	II,27,p	er	me,g93	4 12-	27-1	2 sm		-	
		IF FEMALE:	23c. If yes, outcome of pr	egnancy						23d.	Date of delivery	
Records, P.O. Box 6876( The law requires that the death certificate are has been signed by the attending physogge 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth  Pregnant at time of	dooth -	etal de		Ectopic p	regnanc	у	M	fonth D	ay Year
Box e death the atter	ysic	1 Yes 2 No 9 Unknown	1 · L	death 5 0	ther (	Specify)						
O. Hat the		Part II. Other significant conditions	contributing to death but no	t resulting in the	underl	ying cause giv	en in Part	l.	23e. Did tob	acco us	se contribute to t	he cause of death?
ires that the signed by	d b	Chronic Alcohol	ism						1 Yes	2	No 3 Proba	ably 4 🗸 Unknown
ords	ete								24a. Was an			opsy findings available ompletion of cause of
ecol he law ate has	Completed								perform	ed?	death?	
tal Recian: The certificate	Be	25. Was case referred to medical				26.Place of	f Death (C	heck only				
Vit.	일	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatien	t 3	DOA O	ther <sub>4</sub> _ N	lursing F	łome 5 R	esiden	ce 6 🗸 Other:	Scene
ion of Vital   tending Physician: eath. tor: After this certif the funeral director,	١	27. Manner of Death  1 X Natural 5 Rending	28a. Date of Injury (Month, Day,Year)	28b. Time of	Injury	28c, Injury			d. Describe ho	w injury	occurred	
SiOr Attend death ctor:	ă	2 Accident 5 Pending Investigati					s 2 N					
Division of Vital Records, To the Hospital or Attending Physician: The law requin within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should t	Certification:	3 Suicide 6 Could not determined		home, farm, stre	et, fac	tory, office buil	lding, etc.	28	or Town, Sta		d Number or Rur	al Route Number, City
		29a Certifier	an: To the best of my knowle	edge, death occu	rred at	the time, date	and place	e, and du	e to the cause(	s) and	manner as state	d.
To the within To the comple	Medical	one) 2 Medical Examiner	On the basis of examination and manner stated.	and/or investiga	ation, ir	n my opinion, d	leath occur	rred at th	e time, date ar	nd place	e, and due to the	cause(s)
[ , [ ,	Ž	29b. Signature and title of certifier				29c. License r					ate signed (Mon	
		Thoday U.	King JR.	, le il	).	O.C.M.	.E.	OCA	IE .	Octob	per 10, 2012	
		30. Name and address of person who		•	000	M Daltim -	ro C+	+ Pali	imara MD	2422		
		Theodore M. King, Jr., MD  31. Date filed (Month, Day, Year)	Assistant Medical		_	vv. Baitimo	e Stree	ı, Balt	imore, MD	Z 1 Z Z .	<b>.</b>	
Sta	H:	Date med (worth, Day, rear)	Loz, registrar s olgi	aidi e	1							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 05. Nora Sue Price November 2012 8:13 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Brooke Grove Nursing & Rehab Center Montgomery Sandy Spring 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Director 578-24-1036 1 □ M 2 🛱 F North Carolina 89 02/07/1923 27 is merked other then "natural", or Items 23a or 28a-f shov traumetic event, the Modical Examiner must be notified at 10a State within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montaomeru Rockville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1913 Valley Stream Drive 20851 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Never Married 2 Married Black, White, etc. δ 1 ☐ Yes 2 💢 No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Food & Drug Elementary/Secondary (0-12) College (1-4 or 5+) Classifier Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, should be file and Mental F is merked o ည Virgil Roscoe Lancaster Nora Lee Marlow 1 and 2 should be Health and Meritem 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rand C. Price - Son 14514 Old Lyme Drive, Silver Spring, Maryland 20905 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If Ite
any Injury or ott 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/11/2012 | Rockville, Maryland Parklawn Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, MD 2090# Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiomyopathy disease or condition Weeks Medical resulting in death) Due to (or as a consequence of) Examiner Acute Myocardial Infarction weeks Sequentially list conditions, Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the Dural-transit that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) <u>ام</u> 1 ☐ Yes 2 👿 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D42046 no attending physician November 06, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooke Huffman, M.D., 18430 Brooke Grove Drive, Sandy Spring, Maryland

Registrar
DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Baltimore.

Box 68760

Records, P.O.

**Division of Vital** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 12:30p M Mary Elizabeth Pittore November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Medstar Montgomery Medical Center Olney If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 578-22-9658 Director 1 □ M 2 🕇 F Pennsylvania 89 March 18,1923 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City. Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Bethesda Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 20817 U.S.A. 5706 English Court "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Secretary 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Raumond Marsh Ida Kidwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 English Court, Bethesda, Maryland 20817 Nancy J. Olkewicz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify) Entombment Gate of Heaven Cem. 11/07/2012 Silver Spring, MD Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 232 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a conseq **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 25. Was case referred to medic examiner? 26. Place of Death (Check only one) Hospital: 214 ၉ 1 🔲 Yes atient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending death. 1 Yes 2 No Investigation Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Joly

State Registrar

Ata Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ata Motamedi, M.D., 17904 Georgia Avenue, Suite #304, Olney, Maryland 20832

ate filed NOV 09, 8 2012 32. Registrar's Signature face

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 30, 2012 Daniel Morrison Pyle 1515 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death (exter Brooke Grove Rehabilitation and Nursing Montgonen sande If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Ohio **Funeral** 8. Date of Birth Months Hours Min (Month, Day, Year) 09/28/1932 Ohio 80 Director 386-32-3875 Usual Residence of Decedent 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Germantown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 23a 20000 Sweetgum Circle, Apt. 14 20874 u.s.A. items 2 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc. 1 X Never Married 2 Married o þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced Completed 1958 Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) International permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Editor/Translator Monetary Fund Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Denzil L. Pyle Corinne LeConey 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Jacqueline Pyle/ Brassie Court. Montgomery Village. MD 20886 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lincoln Crematory: 11/07/2012 Brentwood, Maryland 21. Signature of Funeral Service Licens 22.Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 any Neva M0162 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Alzheimer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No ed by the a detached f 1 Yes 2 L g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Physician/ Medical **Examiner** the Hospital or Attending Physician: The law requires that the death cer ficate be executed

Department of H
Important: If itel
any injury or oth
once.

Physician/

Medical

Director

Funeral

by

Completed

Be

မ

Examiner

**Funeral** 

**Director** 

28a-f shov

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

ttending physician or use as the buris ed by the detached within 24 hours after death.

To the Funeral Director; After this certificate has I completely filled in by the funeral director, page 2 s

Division of Vital Records, P.O. Box 68760

0	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Disesse.  Due to (or as a consequence of):	Approximate Interval Between Onset and Death
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	
lical Exa	that initiated events resulting in death) Last	c. Due to (or as a consequence of):	
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery  Month Day Year
sted by Ph	Part II. Other significant conditions co	tructive pulmonary disease	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 X Probably 4 □ Unknown
Comple	Chronic 968	ma once parmonary ousease	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ★ No 1 □ Yes 2 ★ No
Be (	25. Was case referred to medical examiner?	26. Place of Death (Check	
힏	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence 6 NOther (Specify) Living
Certificate:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury 28c. Injury at work?  M 1 □ Yes 2 □ No	8d. Describe how injury occurred
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medical	(Check 2' Medical Exami	sician: To the best of my knowledge, death occurred at the time, date and place, an ner: On the basis of examination and/or investigation, in my opinion, death occurred at the se Practitioner: To the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner states

D56531

8600 snowden River PKWY #301, Columbia, MO21045

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

Harry 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, 6933, 11/9/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV Augustus Russell Retalis 2012 3:50 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1805 Snow Meadows Ln. Unit 301 Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) June -6,3 1953 **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 030-44-9137 Days 59 Director 1 🖁 M 2 🗆 F Maryland Usual Residence of Deceden shov 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or Items 23e or 28e-f sho the Madical Examination and be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1805 Snow Meadows Ln. Unit 301 21209 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Mamied 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 【No Specify Completed 3 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) On Our Own Accountant other traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o Department of Health and Menta Important. If item 27 is marked. any Injury or other traumetin and place. ပ Andrew Retalis Bertha Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Shawker- Cousin 6608 Rapid Water Way Unit 301 Glen Burnie, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 11/9/2012 Baltimore, MD 22. Name and Address of Facility Hubbard Funeral Home Signature of Funeral Service Licenses 4107 Wilkens Avenue Baltimore, MD 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ oronary disease or condition 1,012 Medical resulting in death) Due to (or as a cons Examiner 2009 choleste Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Duate (or as a consequence of) burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed end Due to (or as a consequence of) attending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Dav 5 ☐ Other (specify) 1 Yes 2 No detached the 9 Unknown Division of Vital Records, P.O. ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ pe Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 No Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2360 W. Toppa Rd Lutheri SHARON mp MD 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

			Plea AMEND PI LINE A	se Type or Pri	nt in E	Black I	ndelible Inl	k. Ens	ure A	II Copies	s Are Le	gible	•	
			1 - For State Registrar	Otate of W	ai yiai i		rtificate of E		and iv		Reg. No. 2	01	2 3	35832
	Physicia Medic		1. Decedent's Name (First, Middle,	Reid.						2. Date of Dea Month	ath Day	Year Year		e of Death
	Examin	er	4a. Facility Name (if not institution,  5. Social Security Number	tealth Care		Hem ast birthday)	4b. City, Town, or	Location (	Poi	8. Date of Birt	4c. Count	Ce	112	to as Foreign
h	Funeral Director		110-32-0363	1 XM 2 □ F	70	Yrs.	Months Days	Hours	Min.	05/19			untry) NY	te or Foreign
	aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Ceci	1	10c. City	, Town or L	ocation Cy Point							e City Limits
	with the M 23a or 28 ust be noti	Funeral Dire	10e. Street and Number Bldg 5-H Cir	cle Drive	# E>	ĸec	10f. Zip Code 21902	 2			10g. Citizen of US			
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 又 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates. 1	No		Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No			cify Yes or No- Rican, etc.)		ck, White	rican Indian e, etc. lack	),
2-0	2 hours "natur edical I	Completed	15. Deceden (Specify only highes	t's Education		16a. Dece	edent's Usual Occupa		t of worki	na	16b. Kind of E	Business	Industry	
2121	within 7 giene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5	+)		Driver				Tran	spoi	rtati	.on
and	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, La Preston Edwa	***					er's Name le E	e (First, Middle,	Maiden Surnan	ne)		
Maryland 21215-0036	d 2 should be alth and Ment 27 is marked or traumatic e		19a. informant's Name/Relationsh Charles A Re	ip (Type, Print)			ing Address (Street a	and Numbe	er or Rura	l Route Number				
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1	3  Removal from State	CE	emetery, cre	osition (Name of matory or other place C Crem			Date 2012	20c. Location	•		
3altir	permit. P. Departme Importar any injur		21. Signature of Toneral Service Li		ACI	2	2. Name and Addres	s of Facili	<sup>ty</sup> Sim	plicit	y Cre	m &	Fun	Serv
	d0 = 6 0		23a. Part 1. Enter the disease, or	complications that caused	the death		homasAll ter the mode of dying					Han	Approxi	mate
	hysician/ Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	_a Aspi	1407	100	PNEUMON	IA					Qnset a	Between nd Death 10000
	Examiner	L	Sequentially list conditions,	Due to (or as a	consequi	ence of):								
A	ecuted and I-transit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	conseque	ence of								
30	an an ria	I – I	that initiated events resulting in death) Last	Due to (or as a	ı consequ	ence of):								
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. After this certificate has been signed by the attending physici sted filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 🗀 Fetal	death 3	☐ Ectopic pregnanc☐ Other (specify)	у			1	ate of del	livery Day	Year
s, P.O.	v requires that th s been signed by should be detac	by	Part II. Other significant condition	ns contributing to death b	ut not resu	ulting in the	underlying cause giv	en in Part	I.		obacco use con			of death?
Division of Vital Records,	law requi has been ye 2 should	Completed								24a. Was a			topsy findin completion	gs available of cause of
al Re	sician: The law scrifticate has the scrifticate has the scrot, page 2 s	Be Co	25. Was case referred to medical				26. Pla	ace of Dea	th (Check	1 Yes	2 No	1 Yes	2 No	
f ∑it	Physical this ce	임	examiner? 1 Nes 2 No 27. Manner of Death	Hospital: 1  Inpatie		ER/Outpatie	nt 3 DOA Othe	4 X Nt		me 5 Resid			ify)	
o uo	ending sath. or: After he funei	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day ation	Year)	injury	work'			28d. Describe h	ow injury occur	rea		
Divisi	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer.		3				reet, factory, office			28f. Location (S City or Tow		er or Ru	ral Route Nu	umber,
	n 24 hou n 24 hou ne Funer	Medical	(Check 2 L Medical Ex	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the l	amination	and/or inves	stigation, in my opinio	n, death o	curred at	the time, date ar	nd place, and du	ue to the a	cause(s) and	manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	Ue -	~ A	0. 1	29c. License	number	TIC	2	29d. Date signe	d (Month	n, Day, Year)	CIN
	mx!		30. Name and address of person w	rho completed cause of de	eath (Item	23a (Type,	Print)	X 1-	<u>) (</u>	) ;	shier.	W.	0,0	NO
	Stat	P	Aveling Her 31. Date filed (Month, Day, Year)	incidez Or	D VA	1 WOZ	yard 1-k	<del>Atla</del>	. Ca	e Syst	ien Per	TY	Mill I	M SACA
	Registra		NOV 08	2012	M	15. A	park					•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#25perPHYS, G933, 11/8/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anna Robinson Oct 2012  $3:00 \text{ P}^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Prince Georges Hospital Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 579-24-1393 1 ☐ M 2**X** F 88 10-19-19 N.C. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XYes 2 ☐ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1218 North Carolina Ave, 20002 US be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 🗆 Never Married 2 🗆 Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Administrator</u> Navy Annex Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Jasper Wingate Bertha Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Hinnant (daughter) 9017 Lynnalan Dr., Ft. Wash. MD. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 10-26-12 Landover 22. Name and Address of Facility Terry A. 21. Signature of Funeral Service L Austin Funeral Ser 3821 14th Street NW Wash 20011 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Deshock, or hear failure. List only one cause on each line. Immediate Cause (Final sease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran and Due to (or as a consequence of attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 for use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the af Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco usercontribute to the cause of death? þ Records, 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No completely filled in by the funeral director, page 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗷 No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 5 Pending injury Naturat Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day completed cause of death (Item 23a) (Type, Print)

State

Registrar

filed Month, Day,

NOVO 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6:50 AM Physician/ Patricia Ann Rakes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 213-42-4449 1 □ M 2🏋 F Aug 7, 1944 Maryland 68 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA 715 Beards Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🚺 No Black, White, etc. ģ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygien is marked other the healthcare nursing assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Byron George Loveless Catherine Eleanor Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Rakes/daughter 3654 Churchville Road Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature (Funeral Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between of heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine pue to (or as a consequence on Due to (or as a consequence of): Physician/Medical use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death ☐ Pregnam a
☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an  $\omega$  are runeral Director. After this certificate has completely filled in by the funeral director, page 2  $\approx$ autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Carthying nurse Fractitioner: To the basis of my months of the cause (s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0053568 October Z hesa peake 500 CLAPES C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

MOETMON

32 Registrar's Signature

31. Date filed (Month, Day, Year)

NOVO 8

			Plea	_	-								II Copie		_	ible.		
×82		For State Registrar			State o	of Ma	ırylanı	•	artmer <i>rtificat</i>			and M	flental Hy	/gien Reg. N	21	)   2	2 3	583
Physiciar Medica		1. Decedent's Name Michael Ro							_				2. Date of D Month 10		)ay 2	Year 2012	3. Time o	
Examine	er	4a. Facility Name (if 5713 Mpssr)		-	et and nun	nber)			1	Town, or	Location	of Death			c. County Montgo			
Funeral Director		5. Social Security No. 309–42–742	umber	6. Sex	12□F			st birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)		9. Birth Coul	**	or Foreign
	ctor	Usual Residence of 10a. State	of Decedent 10b. County		, , ,	Ь,		Yrs. , Town or Lo	ocation				8-7-19	41		Indi	10d. Inside (	City Limits
ith the Mar 3a or 28a t be notifi	Funeral Director	10e. Street and Nun	nber				NDCK		10f. Zip				***	,	Citizen of V			s 2 L.I No
fter o	হ	5713 MDSSC  11. Marital Status  1 □ Never Marri 3 □ Widowed	ied 2 ⊠ Mar	12.	Was Dece Armed Fo 1  Yes If Yes, Giv Year or D	orces? 2  N ve							ecify Yes or No Rican, etc.)			e - Ameri k, White,	can Indian, etc.	
vithin 72 hour giene. er than "natu the Medical	Completed	(Spe	15. Decede ecify only highe ondary (0-12)		ition	)	-)	(Give life. L	dent's Usua kind of wo NOT use rmation	rk done a retired)	<i>luring</i> mos	t of worki	ing	Uni	Kind of Bu ted St ormati	ates		
ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (I Benjamin Sa		Last)								er's Nam Kushle	e (First, Middle evitz	, Maider	n Sumame	9)		
nd 2 shou lealth and m 27 is m her traum		19a. Informant's Na Judith Saks	s – Wife		Print)			5713	Mossro	ck Dr			al Route Numb	rylan	d 2085	i2		
Page 1 a tment of H tant: If ite jury or ott		20a. Method of Disp 1 ☑ Burial 2 ☐ 4 ☐ Donation	Cremation		noval from	n State	Ce	lace of Disp emetery, cre lean Mer	matory or o	ther plac	1		Date 5-2012		ey, Ma	-	own, State	
permit Depar Impor any in once.		21. Signature of Fur	neral Service	Licensee	Edwar	d Sag	el						ard Sagel kville,				ion	
hysician/ Medical		23a. Part 1. Enter t shock, or heal Immediate Cause ( disease or condition resulting in death)	rt failure.List ( (Final	only one ca	ause on ea	ach line. ced B		r Cance		e of dying	g, such as	cardiac o	or respiratory a	arrest,			Approxima Interval Be Onset and	etween
Examiner	ner	Sequentially list co	nmediate	b												-		
o 6 ⊆	cal Examiner																	
ifficate ng phys	Medi	IF FEMALE:	•	d														
To the Hospital or Attending Prysician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the by	Physician/Medica	23b. Was decedent in the past 12 r 1  Yes 2  9  Unknown	months?	23c.	If yes, ou 1  Live 4  Preç 9  Unk	Birth 2 gnant at	☐ Feta	I death 3	Ectopic Other (s)		:у				23d. Dat Mo	te of deli	very Day	Year
quires that ti en signed by ould be deta	≥∣	Part II. Other signif	ficant conditi	ons contril	buting to o	death bu	t not resu	ulting in the	underlying	cause giv	ven in Part	I.					the cause of	
: The law re cate has be r, page 2 sh	Completed												24a. Wa aut per 1  Yes	opsy formed?	F	orior to co death?	opsy findings ompletion of 2  No	available cause of
/sician s certifi directo	To Be	25. Was case referre examiner?  1 \sum Yes 2 \bar{2}			pital:	Innatie	nt 2 $\square$	ER/Outpatie	ent 3 🗆 D	Othe	ace of Dea		k only one) ome 5 🕅 Res	idence	6 □ Othe	er (Specif	5/)	
ending Physath. or: After thi he funeral	Certificate: 1	27. Manner of Death  1 🕅 Natural  2 🔲 Accident	5 🗌 Pendi _ Invest	ng igation	28a. Date		/	28b. Time o injury		8c. Injury	/ at		28d. Describe				,,	
ital or Att urs after d ral Direct	al Certi	3 ∐ Suicide 4 ☐ Homicide	6 ∐ Could determ	nined	build	ling, etc.	(Specify)						28f. Location City or To	wn, Stai	te)			nber,
thin 24 hor thin 24 hor the Fune	Medical (	(Check 2	Certifying  Contifying  Contifying	Examiner: 9 Nurse Pi	On the ba	isis of exa	amination	and/or inve	stigation, in e, death occ	my opinio urred at t	on, death o	ccurred at	t the time, date	and place the cau	ce, and due se(s) and m	e to the ca	ause(s) and m stated.	nanner stated
5.858		30. Name and addr	14	$\frac{\mathcal{M}}{\mathcal{M}}$	راد (	una of da	n.	, ) -		D0053			:	29d. L	10-25		Day, Year)	
5		John Wallma	ark, MD				-		·	ille,	Maryl	and 2	0850		<u></u>			
State Registra		31. Date filed (Mont	th, Day, Year)	3 2012		egistrar	's Signat	ure	arke	,								

			AMEND #26, PER	se Type or Pr VERBAL G933	int in Blac	k Ir	ndelible Inl	k. Ens	ure A	II Copie	s Ar	e Leg	ible.		
			For State Registrar	State of N			artment of F tificate of L		and iv	ientai Hy		20	113		836
	Disconicion		Decedent's Name (First, Middle)	, Last)			THIS COLOR OF L	<del>Joan</del>		2. Date of De			2 1 6	3. Time of	0 0
	Physicia Medi		Theodore Kay	Sanderso	n, Jr.					Octobe	r 2	$\overset{\text{Day}}{4}$ , 2	012	2:35	AM .
	Examir	ner	4a. Facility Name (if not institution,	,			4b. City, Town, or		of Death		4	c. County			
-	Funeral	_	6029 Loreley Be 5. Social Security Number		ge (In yrs. last birth	day)	White M If Under 1 Year		24 Hrs.	8. Date of Bir	th	Balt		nplace (State o	r Foreign
	Director		213-36-8065 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	77 Y	rs.	Months Days	Hours	Min.	(Month, Da 05/15/	193 193	5	Mar	y Iand	
	and show	ö	10a. State 10b. County		10c. City, Town	or Loc	cation							10d. Inside Ci	ty Limits
	Maryi 28a-f otifie	Director		imore	White	Mai	rsh							1 🗌 Yes	2 <b>X</b> No
	ith the 3a or t be n	alD	10e. Street and Number				10f. Zip Code				_	Citizen of V		untry?	
	ems 2	Funeral	6029 Loreley Bo	each Road  12. Was Decedent	Ever in U.S.	13 V	21162 Vas Decedent of Hi	ienanic Ori	ain? (Sne	city Yes or No-		U.S.A			
9	ter de , or its amine	þ	1 ☐ Never Married 2 🔀 Marr	ied Armed Forces		11	Yes, specify Cuba	n, Mexicar	i, Puerto F	Rican, etc.)			k, White	ican Indian, , etc.	
8	ours at ttural"	eted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		<u> </u>	Yes 2 No					Specify:	N	Mhite	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed		t's Education st grade completed)		Give k	ent's Usual Occupa ind of work done of NOT use retired)	ation during mos	t of workir	ng	16b.	Kind of Bu	isiness li	ndustry	
21	s should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Med		Elementary/Seconday (0-12)	College (1-4 or 4	O+)		ctor of (	)pera	tions	5		Ship	pin	g	
and	be filed vental Hygredothe	To Be	17. Father's Name (First, Middle, L							(First, Middle,					
Maryland	ould b nd Mel mark matic		Theodore Kay  19a. Informant's Name/Relationsh	Sanderson		h A - III -	- Address (Otrost	Mar		Laure			eck!		
	and 2 sh Health ar tem 27 is		Frances L. San		100		g Address (Street a Loreley							,	2
ore,			20a. Method of Disposition  1  Burial 2  Cremation		20b. Place of I	Dispos				ate				Town, State	
Baltimore,			4 🛛 Donation 5 🗆 Other (S	pecify)		_Gi	fts Registr	y 1		/2012			·	ryland	
Bal	permit. Pag Departmen Important: any injury		21. Signature of uner Service	celsee			Name and Address			-				-	176
		Н	23a. Part 1. Enter the disease, or	complications that cause	d the death. Do no			-				1101101	/CL/	Approximat	
****	Physician/		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on e in lin	helm	Λ	dur	ews	e				- 1	Interval Bet Onset and I	Death
-	Medical Examiner		resulting in death)	a. Due to (or as	a consequence of	):	<i>V</i> ·3	CNO					_	8 100	دمر
		er	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a consequence of	١٠							-	· · · · · · · · · · · · · · · · · · ·	
	d d ansit	Examiner	Cause (Disease or linjury that initiated events	Due to (o) as	a donsequence of	,.									
	executed ian and irial-transit		resulting in death) Last	Due to (or as	a consequence of	):				-					
68760	ate be physic the bu	edic		d	··-·								-		
89	certific nding use as	M/n	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23d. Dat	e of deli	venv	
Вох	The law requires that the death certificate be attending physic page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal death at time of death		Ectopic pregnanc Other (specify)	У				Mor			/ear
P.O.	at the de by the detach		9 ☐ Unknown  Part II. Other significant conditio		out not resulting in	the ur	nderlying cause giv	en in Part I	1.	23a Did t	obacco	usa contri	huta to	the cause of d	ooth?
S,	uires the signer of signeral did be a	Completed by	Cervical	STENOSIS	_		, , ,			1 🗆		~/		obably 4 🗆	- 1
of Vital Records,	w requ	plete	RPH							24a. Was				opsy findings a	
Rec	The la ate ha page (	Som		-						auto perfo	rmed?	d	eath?	ompletion of c	ause of
ta	ician: čertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ace of Deat	th (Check					N	
of V	Phys rrthis eral dir	은 ::	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpat 28a. Date of inj	ient 2 ER/Outp		28c. Injury	4 ∐ Nu		ne SResidente Residente Re				y) 1305/	<del>)/ (2</del>
on (	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 ccident Investig	ation	ry, Year) inju	ury	work'			od: Doscribe i	iow inju	ny doddino			
Division	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		ury - At home, farn c. (Specify)	n, stre	et, factory, office		2	8f. Location (S			r or Rura	al Route Numb	er,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but		29a. Certifier 1 Certifying	Physician: To the best o	f my knowledge, de	eath o	ccured at the time	date and r	place and	due to the ca	use(s) s	and manne	r as stat	ed	
	the Ho nin 24 l the Fur	Medical	(Check 2 \(\sum \) Medical Ex	caminer: On the basis of on Nurse Practioner: To the	examination and/or i	investi	gation, in my opinio	n, death oc	curred at t	he time date a	and place	e and due	to the ca	ause(s) and ma	nner stated.
	Voint Voint Con		29b. Signature and title of certifier	20.01-			29c. License	number	21		29d. D	ate signed	(Month)	Day, Year)	
			30. Name and address of person w	the completed cause of	leath (Item 22a) /Fi	ne D.	int)	11	21		(	2/2	4	12	
_			KTER R	AB NS		10, 11	Hopkin	VJ	Hos	ATA	1				
	Stat Registra		31. Date filed (Month, Day, Year)		ar's Signature	23	and		,	1					

AMEND 24A-30 PE RMD State of Maryland 2 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2012 3:50 Рм Michael Sumler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1130 Madison St Suite A4 Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 1, Day 1951 Months Days Hours Maryland **Director** 1 🙀 M 2 🗆 F 60 217-58-1822 Usual Residence of Deceder show 10a. State 10d. Inside City Limits than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 🙀 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21401 110 Clay St; Apt D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 XNo 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)  $\stackrel{\text{Elementary/Secondary (0-12)}}{10}$ restaurant waiter permit. Page 1 and 2 should be filed wi Department of Health and Mental Hyge Important: If item 27 is marked other any injury or other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Mary Evelyn Johnson Jonas Roosevelt Sumler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Newton Dr Apt C; Annapolis, MD 21403 Joyce Sumler - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) in state cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board inat cof Room dicadi Mide, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final INFILL CANCELL Onset and Death Physician/ ADVANCED disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially listed dilices, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 the ' as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2X within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 🗌 Yes 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of de 29d. Date signed (Month, Day, Year) MEDICAL ONLOW, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAUN GAPG. ANNAPOLIT ONICLOGY, 2003 MEDICAL PKWY #210 ANNAPOLIS MD 21401 31. Date filed (Month, Day, Year) Registrar's Signature State MOA 0 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STOKES Month | Day 05 Year 12 Physician/ H1320TMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 522 Richwood Avenue Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Months Days Director 220-22-4451 1 M 2 □ F 02/20/1930 MD Usual Residence of Decede 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location death with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 M Yes 2 No **Baltimore** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 21212 USA 522 Richwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Allied Chemical 8 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Conners Harry Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Richwood Avenue, Baltimore, MD 21212 Rosie M. Stokes / Wife Baltirhore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖪 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 11/14/2012 Owings Mills, MD Garrison Forest Veterans Cemetery ! 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final condiovascular Priysiciani disease or condition Medical resulting in death) s consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 $\zeta$ Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No After this certificate has been signed by the infuneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No æ Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\overline{\Omega}\) Residence 6 \(\sum \) Other (Specify) |₽ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21217 Boel

Registrar

31. Date filed (Month, Day,

NOV08

2012

1

LO

ack

12000

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 11:05 AMM Jane H. Steensma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 9638 Alda Drive Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Hours Min Days 66 **Director** 569-64-0334 1 🗆 M 2 🔀 F Dec 3, 1945 Iowa Usual Residence of Decedent 23a or 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Parkville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 9638 Alda Dr. items ; within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2X Married ò þ Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 💢 No Specify: "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) healthcare nursing aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Albert Lawlor Jean Smit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 9638 Alda Dr; Baltimore, MD 21234 Jerry Steensma - husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signatu FF Lervin License 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Small Cell Metastatic can or disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the ar Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ☐ Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 은 s after death.

I Director: After this of in by the funeral d 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

120000

NOV 0 8 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505

mo

Hop Kins

Registrar's Signat

00658893

Baynew Crale

November

Baltinore

2

2/224

2012

			Please	Type or Print in State of Maryla						lible.
		1	For State Registrar	State of Maryla			of Death		Reg. No. 2	112 35840
	Physicia Medic		1. Decedent's Name (First, Middle, Las Ronard LEE					2. Date of Dea	th	3. Time of Death
· .	Examin		4a. Facility Name (if not institution, give	street and number)		1 6	wn, or Location of Do	eath .	4c. County	of Death
Sugar.	Funeral		UNION MEMORIA 5. Social Security Number 6. So	ex 7. Age (In yrs	. last birthday)	If Under 1		Hrs. 8. Date of Birth	) Vearl	Birthplace (State or Foreign Country)
	Director		213-62-6144 1 Usual Residence of Decedent	<b>№</b> м 2 🗆 ғ	58 Yrs.	Months	Days Hours IV	09-22		MD
	show d at	tor	10a. State 10b. County		City, Town or L					10d. Inside City Limits
	Mary 28a-f	Director	MD		BALTI					1 <b>Ø</b> Yes 2 □ No
	vith the 23a or st be		10e. Street and Number 418 E. 21 ST	REET		10f. Zip C	ode 21218		10g. Citizen of V	SA
	items	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13		nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		e - American Indian, ck, White, etc.
920	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.  27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 PNo If Yes, Give Year or Dates.			No Specify:	,		Black
21215-0036	2 hour "natu	Completed	15. Decedent's E (Specify only highest gra		(Giv	edent's Usual C e kind of work o	done during most of	working	16b. Kind of B	usiness/Industry
121	within 7 giene. er than		Elementary/Secondary (0-12)	College (1-4 or 5+)	1	DO NOT use re ITRACT	_		Consi	RUCTION
nd 2	l be filed w tental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last)	UNK	1		18. Mother's	Name (First, Middle,	Maiden Surnam	е)
Maryland	ad Men marke matic		19a. Informant's Name/Relationship (7	vne Print)	19b Ma	iling Address (9		r Rural Route Number	City or Town 5	State Zin Code)
	d 2 shou alth and 1 27 is m er traum		Takeeta Gardi	ner/DAughter	130	8 Kent	on Road.	Baltimor	e, MO	. 21234
Baltimore,	ge 1 and 2 nt of Healt titem 2 or other		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐	Removal from State	<ul> <li>Place of Disp cemetery, cr</li> </ul>	oosition (Name ematory or othe	of er place)	Date	20c. Location	- City or Town, State
Itim	permit. Page Department of Important: If any injury or once,		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service License	fy) C	ematin	22 Name and	MD   /	1/4-12	BAUTT	nort, MD inerac Securces 0.2122
Ba	Ped du de		13m 8 8	Ca MIVE	16	4905 Y	INK Road	1. BATIA	lore, Me	0.21212
	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	15 - i	nter the mode o		diac or respiratory an	est,	Approximate Interval Between Onset and Death 2 days
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	equence of):					
1	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):					
0	be exercian sician burial	20	resulting in death, East	d						
928	rtificate ing phy e as th	Med	IF FEMALE:							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of predictions of the control	etal death 3	☐ Ectopic pre				ate of delivery onth Day Year
s, P.O.	ires that the signed by Id be deta	d by Pi	Part II. Other significant conditions of	contributing to death but not	resulting in the	e underlying car	use given in Part I.			tribute to the cause of death?  3  Probably 4  Unknown
cord	law requ nas been e 2 shou	nplete						24a. Was		Were autopsy findings available prior to completion of cause of death?
l Re	n: The ficate or, pag		25. Was case referred to medical				26. Place of Death (	1 🗆 Yes		1 Yes 2 No
Vita	ysicia is cert direct	To Be	examiner? 1√2 Yes 2 □ No	Hospital:	☐ ER/Outpat	ient 3 🗆 DOA	Other	ing Home 5 🗆 Resid	dence 6 ☐ Oth	ner (Specify)
n of	ding Ph th. After th funeral		27. Manner of Death 11 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year,	28b. Time injury		c. Injury at work? 1 🔲 Yes 2 🗆 No		ow injury occur	red
Division of Vital Records,	al or Atten s after dea! al Director: ed in by the	I Certificate:	3 Suicide 6 Could not I	pe 280 Place of Injuny - A	t home, farm, s cify)	street, factory, o	office	28f. Location (S Cify or Tov		per or Rural Route Number,
_	Hospi 24 hour Funera etely fill	Medical	(Check 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examina rse Practitioner: To the best	ation and/or inv	estigation, in my	y opinion, death occu	rred at the time, date a	and place, and du	ue to the cause(s) and manner stated.
	To the To the Comple	Ž	29b. Signature and title of certifier	SC. Facultioner. To the best	o. my knowled	29c. l	License number		29d. Date signe	ed (Month, Day, Year)
			Matula	und 1	ハ・カ		72438		<del></del>	12012
	7		30. Name and address of person who KAV111A KAKKAD. MED	completed cause of death (I	tem 23a) (Type PRIAZ HO	SPITAL	201 E. U.	NIVERSITY PE	RKWAY.	BALTIMORE 21218
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature				,	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 4:00 P M November Roland Nelson Spaide Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6012 Chesworth Road Catonsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 28 Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 1 X M 2 🗆 F Min 89 **Director** 190-14-6977 1923 Pennsylvania Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6012 Chesworth Road 21228 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1943–46 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working (Give Nor of the doring most of life DO NOT use retired)
Computer Operations
Supervisor Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ John M. Spaide Ella May Balliet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7499 Windswept Court; Sykesville, MD 21784 Joyce Smith Daughter Department of Health Important; If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Dorrance Emmanuel

Cemetery 1 X Burial 2 Cremation 3 Removal from State Emmanuel 11-10-2012 Dorrance, Pennsylvan
22 Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 4 Donation 5 Other (Specify) Pennsylvania 21. Signature of Furleral Service Line 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NO disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** vears Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Pregnant at time of death Month Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy After this certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1X Natural 5 Pending Accident Investigation 24 hours after deatl Funeral Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Considering Nurse Practioner: To the best of my knowledge death occurred at the time, date and due to the cause(s) and manner as stated. (Check the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 2 2012 dress of person who completed cause of death (Item 23a) (Type, Print) 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOVO 8 Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2012 Alice Steele Novemebr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Harmony Hall Assisted Living Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 18, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Maryland 577-14-3318 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wedfoal Evan increust be notified at once. 10a. State 1 ☐ Yes 2 ▼No Director Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21044 6336 Cedar Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Yes. Give Specify: \$ **Black** 3 X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Claims Examiner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Ann Butler William Proctor ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5653 Thunder Hill Road Columbia, Maryland 21045 Barbara Johnson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cemetery, crematory or other place). Christ Episcopal Church Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-10-2012 4 Donation 5 DOther (Specify) Columbia, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funefall Service Licenses 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ner calcemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eleby filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 No 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di letely filled ir Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who dompleted cause of death (Item 23a) Type, Ka2115 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ C. Poper 03am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** VMHuest andalishma Amore County 8. Date of Birth (Month, Day, Ye Aug 17, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Maryland Days Hours Min 1 🕅 M 2 🗆 F Yrs Director 214-16-8362 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 ☐ Yes 2√ No MD Baltimore **Baltimore** 10e. Street and Numbe 10g. Citizen of What Country? Funeral 6825 Campfield Road #3A 21207 USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner I Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Black, White, etc. à 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 3 Divorced 4 Divorced Completed 143-45 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and 2 should be fill Health and Mental 0 Martin Emil Staehlin Josephine Elizabeth Love Department of Health and M Important: If item 27 is man any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selma Staehlin/spouse 6825 Campfield Road #3A Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date . Page 1 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Sig atur of Funeral Service Licens Ade State Anatomy Board 655 W. Baltimore Street Director MD timore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Atherosclerche er orany arkny years Medical (or as a consequence of): **Examiner** urtensum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine (or as a consequence of) perlipidemo that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year been signed by the s should be detached P.O. Part II. **Other significant conditions** contributi*ng* to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s has performe certificate 1 ☐ Yes 2 ☐ No Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 XNO ٩ 1 Inpatient 2 ER/Outpatient 3 I □ Nursing Home 5 □ Residence 6 □ Other (Specify) within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending work' 1 Yes 2 No □ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

completed

Medical

29a. Certifier

29b. Signature and title of certifier

NOA U

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Re

old

5401

1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Cruict Rd

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Kandallstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:12 PM Edna Sooknanan 26 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ESPU Birthplace (State or Foreign Country) 8. Date of Birth If Under **Funeral** If Under: Months (Month, Day, Year) **Director** 565-94-7117 59 July 8, 1953 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 ☐ Yes 2 😾 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 683 W. Main Street 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc ō, by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: white 3 ☐ Widowed 4 🏋 Divorced Completed any injury or other traumatic event, the Medical Scoknanan, Edna 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) nurse healthcare Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Balfour/daughter 9155 Sibbald Road Jacksonville, FL 32208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 N Other (Specify) Signature of Funeral Strvice Licer 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 Director ,655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? for Month Dav Year Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes Yes 2 Be 25. Was case referred to nedical 26. Place of Death (Check only one) 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify) 1 🗌 Yes TOSPICE nours after death.

neral Director: After this or
filled in by the funeral dire မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 \sum Yes 2 🔲 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERN SHORE DR. SALISK

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BRENDA SYDNORMINICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINC SILUER 055 MONTGOMERY OSPITAI HOLY If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** 051-40-7307 Director 1 □ M 2 🛛 F New York 2 should be filed within 72 hours efter death with the Marylend filth end Mental Hygiene.
27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Example must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No SILVER MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20906 2949 HEWITT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced BLUACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) special needs caregiver Be 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) Early B. Sydnor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 shi Department of Health en Importent: If item 27 is eny injury or other treu once. CROSS HOSPITA CLEN 20910 HOLY FOREST 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Tomer (Specify) in 21. Signal are of Euneral Service die. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CARDIOPULMONARY ARREST disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ORGAN TIPLE FAILURE Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the ettending physiclan end ched for use as the burial-transit INFAR WOIT that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e Hospitel or Attending Physicien: The law requires thet the death certificete be 124 hours efter death.

• Funerei Director: After this certificate hes been signed by the ettending physicis e Funerei Director: After this certificate hes been signed by the ettending physicis listely filled in by the funeral director, page 2 should be detached for use as the bu CHRONIC KIDNEY DISEASE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **M**Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hospi within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 65069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREST EMME GLEN a SI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			<ol> <li>Decedent's Name (First, Middle, Las</li> </ol>	t)						
	Physicia		Lillian J. Ship	ne						
	Medic		4a. Facility Name (if not institution, give				4b. City	Town or	Location	of Deat
	Examin	er	20 Hammarlee Ro	,						
			5. Social Security Number 6. Se			d=	If Under		Burn	
0.0	Funeral		,	9	e (In yrs. last birtho 79	iay)	Months	Days	Hours	Min.
	Director			□ M 2 <b>X</b> F	/9 Y	rs.				
	D wo	_	Usual Residence of Decedent  10a. State 10b. County		40e City Town		ntion	-		
	/land f sh	흕	,		10c. City, Town o					
	Many 28a-	ē	MD Anne	Arundel	GLen	В	ırnie	3		
	or or		10e. Street and Number				10f. Zip			
	vith 23a st b	Completed by Funeral Director	20 Hannarlee Rd	; Apt 220			21	1060		
	ath v	Š	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decec	lent of Hi	spanic Or	iain? (S
	r de	Y F	1 Never Married 2 Married	Armed Forces		If	Yes, spec	ify Cuba	n, Mexica	n, Puert
36	afte Il", c	a P	3 ☒ Widowed 4 ☐ Divorced	If Yes, Give	NO	1	☐ Yes	2 🗶 No	Specify	<i>c</i>
8	tura al E	te		Year or Dates.				1.0		
75	"na "na edic	롈	15. Decedent's Ed (Specify only highest gra		(0	Give kı		rk done a	ation <i>luring mo</i> s	st of wo
2	he.	E	Elementary/Secondary (0-12)	College (1-4 or 5	+)		NOT use	retired)		
2	with /gier <b>ner t</b>	ပ		0		cle	rĸ			
pu	filed al H	Be c	17. Father's Name (First, Middle, Last)						18. Moth	ıer's Na
<u>a</u>	l be lents rkec tic e	우	Herman Leslie St	rickland				.	Man	ry M
چ	ould nd N ma		19a. Informant's Name/Relationship (T)	/pe, Print)	19b. I	Mailing	Address	Street a	and Numb	er or Ru
Š	2 sh thai thai trai		Robin Hook - da	mohter					vale	
ຜົ	and Heal		20a. Method of Disposition	agircer	20b. Place of D	_			1	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery,	crem	atory or o	ther plac	:e)	
Ξ.	Pag neni a <b>nt:</b> ury (		4 X Donation 5 Other (Specif							
at	mit.		21. Signature of Funeral Service Licens	Diag	ector	22.	Name an	d Addres	s of Facil	ity <b>S</b> t
m	permi Depar Impo any ir		120001	Wade, Dir	CLOI		655 V	V. Ba	altin	ore
		$\vdash$	23a. Par 1, Enter the disease, or comp	olications that caused	the death. Do not	t enter	the mod	e of dyin	g, such as	cardia
			shock, or heart failure. List only of	ne cause on each line	t.			_		
, manage	Physician/		Immediate Cause (Final disease or condition	ME	TASTA	TT	10	MAN	ICR	LAS
	Medical		resulting in death)	Due to (or as a	consequence of)	:				
	Examiner		Commentally like a conditions	b. —						
		cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate		consequence of)	:				
	ted Insit	Ē	cause. Enter Underlying Cause (Disease or injury							
	and and al-tra	Ä	that initiated events resulting in death) Last	Due to (or as a	a consequence of)	:				
	cian cian	<u></u>								
ox 68760	ath certificate be executed attending physician and for use as the burial-transit	βį	_	d						
87	tifice ng p	Me	IF FEMALE:							
9 ×	endi r use	an/	23b. Was decedent pregnant	23c. If yes, outcome of Live Birth	of pregnancy 2  Fetal death	3 🗌	Ectopic	oregnand	CV .	
30	leath e att		in the past 12 months? 1  Yes 2 No	4 Pregnant at		5 🗌	Other (sp	pecify)		
. B	the cache	Completed by Phys	9 Unknown	9 🔲 Unknown						
P.0	hat t ed b deta	y P	Part II. Other significant conditions co	ontributing to death b	ut not resulting in	the ur	derlying	cause giv	en in Part	: I.
·ń	res t sign d be	유								
ĕ	equi een houl	ate								
00	aw nas b	혈								
è	The I	0								
=	iffica tor, p	Be	25. Was case referred to medical					26. Pla	ace of Dea	ath (Che
/its	sicia	70 B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	ent 2 🗆 ER/Outp	otiont	3 🗆 D0	Othe	ar.	
+	Phy this ral c	F	27. Manner of Death	28a. Date of injur				8c. Injun		lursing l
0	ling 1. After fune	Certificate:	1 XNatural 5 ☐ Pending	(Month, Day				work	?	7
ō	eath or: /	iji	2 Accident Investigation 3 Suicide 6 Could not be	e -			М		Yes 2	J No
/is	r Att	ert	4 Homicide determined	28e. Place of Inju building, etc	ıry - At home, farn :. <i>(Specify)</i>	1, stre	et, factory	, office		
Division of Vital Records,	s aff	0		, , ,	(-)3)					
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical		sician: To the best of						
	9 Ho 24 I 9 Fu	ed		ner: On the basis of ex se Practitioner: To the						
	o the	2	29b. Signature and little of certifier	/	si my mown	-90,			number	uniu
_	FSFÖ		1911111	1. Mi	)		-			74
			7 2 00000	0 100	<u></u>			- i /		//
		ļ	30. Name and address of person who o	completed cause of de	eath (Item 23a) (Ty	pe, Pr	int)	10.	16	DA
			EW COLE SI	AGNES	700	1	IUN	1/11	15	DH
	Stat		31. Date filed (Month, Day, Year) NOV 0 8 201	2. Registra	r's Signature		4			
	Registra	ar	NOV U O ZUI	- Alexan	10.19	ass	-			

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Month 2012 6:00 PMM October 5. 4c. County of Death Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Virginia Aug 23, 1933 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? specify Yes or No-to Rican, etc.) 14. Race - American Indian, Black, White, etc White 16b. Kind of Business/Industry rkina telephone company ıme (First, Middle, Maiden Surname) Magadeline Liverman ural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21060 20c. Location - City or Town, State Date ate Anatomy Board St; Baltimore, MD 21201 c or respiratory arrest, Approximate
Interval Between
Onset and Death 5 CANCER 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s) and manner stated. place, and due to the cause(s) and manner as stated. KT. MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SELLMAN EDWARD) 9.00 A 2 0 1 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ALICE MANOR Nuramp Itm Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days Year 1950 1 X M 2 □ F Months Hours March 8, Mary land Director 220-52-7075 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director notified Yes 2 No 28a-f Baltimore MD 10e. Street and Number 10f. Zip Code 21218 10g. Citizen of What Country? ö ms 23a or must be r Funeral with 1 520 E. 27th St. "natural", or items dical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Cup Corp. warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Anna Marie Yingling George Edward Sellman Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 18 Mariners Way; Stevensville, MD 21666 Katherine Burrier - sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signatur of Funeral Say ice Licenses Wards , Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Progressive Decline Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury Cerebrovascular Accident that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Diabetes Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) Pregnant at time of death the g Unknown g Unknown signed by to be a detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seizure 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 certificate 25. Was case referred to medical examiner?

1 Yes 2 funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined

State Registrar

neted

within 2

To the I

complete

٥

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

NOV 0 8 2012

DHMH 17 Rev 7/2009

MI

MD

3 Registrar's Signature

1 🖵 🇲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D31464

29d. Date signed (Month, Day, Year)

10/

821 N. GUTAW ST Font 308 BACTIMONE MU 21201

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5,9,11,12,15&16a&b Per ANA BD C933 11/09/2012 Jh State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month 1045 Physician/ A ochneic lizabeth Oct Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** atons ville Baltimore Haven Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1174: 6. Sex 5. Social Security Number **Funeral** Hours 95 1 □ M 2 🔀 F Director 214-14-8204 Maryland Aug 16, 1917 Usual Residence of Decedent or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County **Funeral Director** 1 Yes 2 No Baltimore MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 4223 Berger Ave. 12. Was Decedent Ever in U.S. Armed Forces? Unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status -unk Black, White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Completed by Yes 2 No Saltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled -unk -unk Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 E. Baltimore St; Baltimore, MD 21202 Pamela Klecan – legal guardian 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Ade, Director 22. Name and Address of Facility State Anatomy Board perature of Funeral Stryice Land 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 2 No certificate Yes 2. 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) filled in by the funeral 28b. Time of 28c. Injury at work? 1 □ Yes 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗆 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou

To the Funer

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗀 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28595 0 treeey 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1525 () WINGS MI) IASNEEM MI 0. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 1:00 October AM Larry Savage 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care - Irvington Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 28, Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign
Country) 1 X M 2 □ F North Carolina 59 218-56-1335 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21215 2501 Violet Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) welding laborer unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 N. Montford Ave; Baltimore, MD 21213 19a. Informant's Name/Relationship (Type. Print) Warren Smith - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Licensee, Ronal J. S. Director 655 W. Baltimore St; Baltimore, MD 21201 mille 23a. Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Course (Final disease or condition resulting in death) OH= STAGE Due to (or as a consequence of): ROFUUND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of)

Physician /Medical Examiner Hospital or Attending Physlclan: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760,

Physician

Examiner

**Funeral** 

**Director** 

ral", or items 23a or 28a-f show Evaritmer rust be notified at

er than "natural",

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "rany Injury or other traumatic event, if any once.

Director

Funeral

<u>ک</u>

Completed

Be ၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Exami attending physician for use as the buria Be Completed by Physician/Medical certificate has been signed by the rector, page 2 should be detached? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To

	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal dea  4  Pregnant at time of death  9  Unknown					. 2	3d. Date of de Month	livery Day	Year
Part II. Other significant conditions c	ontributing to death but not resulting	in the underlyin	g caus	e given in Part I.	23e. Did	d tobacco us	se contribute to	the cause	e of death?
					1 [	Yes 2	]No 3∏Pi	obably	4 Unknown
					pe	as an topsy rformed? 2 10 No	prior to death?	utopsy find completion 2 \(\sigma\) No	dings available n of cause of
25. Was case referred to medical examiner?				26. Place of De	ath (Check only	y one)			
exammer? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3	DOA	Other: 4 Nursing I	Home 5 ☐ Re	sidence 6	☐Other (Spe	cify)	
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	Time of Injury M	28c.	Injury at Work? 1 □Yes 2 □ No	28d. Describ				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, fac	tory, of	fice	28f. Location City or 7	(Street and own, State)	d Number or R	ural Route	Number,
	ysician: To the best of my knowled inner: On the basis of examination and manner stated.								iuse(s)
29b. Signature and title of certifier	٥		29c. L	icense number		29d. Date	e signed (Mont	h, Day, Ye	ear)

D71264

10/19/2012

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

UZO UNEGBU, MO 7350 VAN DUSEN RD SWITE 220 LAULEL, MD 20707.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G933 11/79/2012 JH

	•	For State Registrar		State 0	i war	yiana /		ırımen <i>tificatı</i>			and iv	ientai Hy	Glene Reg. No		
Physicia	n/	Decedent's Name (First,	,									2. Date of De Month		20	a. Time of Death?
Medic	al	Louis Rob  4a. Facility Name (if not ins				AKA R	ober					Novem	<u>ber</u>	06, 201	
Examin	er	12500 Po	-		ber)			4b. City,		Location Potoi			40	County of Dea Mov	ath Utgomery
Funeral		5. Social Security Number	6. Sex		7. Age (Ir	yrs. last b	irthday)	If Under	1 Year Days	If Under	r 24 Hrs.	8. Date of Bir (Month, Da		9. B	irthplace (State or Foreign country)
Director		<del>097</del> -22-041 Usual Residence of Dece		Ом 2□ F		82	Yrs.		5.1,5	riodio		May 01			New York
land show	tor		County	•	10	Dc. City, To	wn or Loc	ation						<u>-</u>	10d. Inside City Limits
e Mary r 28a-i notifie	Jirec		Montgo	mery						Beth	esda				1 ☐ Yes 2 🔯 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	<b>Funeral Director</b>	10e. Street and Number 10100 L	.anahor	ne. Cou	rt.			10f. Zip	Code	208	17		10g. C	itizen of What C . U	Country?
death r items		11. Marital Status		12. Was Dece Armed For	dent Ever	r in U.S.	13. V	Vas Deced Yes, spec	ent of His	spanic Or	rigin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh	
rs after Iral", o	ed by	1 ☐ Never Married 2 3 💢 Widowed 4 ☐ D		1 ☐ Yes If Yes, Give Year or Da	е			☐ Yes						Specify:	White
72 hou "natu ledica	Completed		Decedent's Edu ly highest grad			16	(Give k		k done di	tion uring mos	st of worki	ng	16b. F	Kind of Busines	s/Industry
within jiene. er thar the M		Elementary/Secondary	(0-12)	College (1-	4 or 5+)		life. DC	O NOT use	retired) Real	tor				Real	Estate
ital Hyged of oth	To Be	17. Father's Name (First, N				•		-		18. Moth	ner's Name	e (First, Middle,	_	,	
ould be id Men mark matic	_	19a. Informant's Name/Re		aham Si	nith		01. 14. 11.						e Le		
nd 2 sh salth ar n 27 is er trau		Andrea Sper			er									r Town, State, 2 , Maryl	and 21044
ge 1 ar it of He : Witen or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cre	mation 3 🗓 F	Removal from			tery, crem	atory or o	ther place			Date		ocation - City o	
nit. Pagartmer ortant Injury		4 Donation 5 0					Davie	d Men	Grd	ns :	11/08	3/2012	Fal	els Chw	ich, Virginia
permi Depar Impo any Ir		1 Jarry	太ソ	mi A	1007	109	113	800 N	ew H	amps	mire hire	es-kina Ave.,S	ilve	runera r Sprin	2 Home, Inc. 1g,MD 20904
		23a. Part 1. Enter the dise shock, or heart	ease, or compl e. List only one	ications that c cause on ea	aused the	e death. Do	not ente	r the mod	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	-			tic N		nall	Cell	Lun	3 Car	icer			Onset and Death  1 Year
Examiner	L	Sequentially list condition		Due to (	O1 43 4 CC	Jilooquene	o 01).								
ad sit	mine	Sequentially list condition if any, leading to immunic cause. Enter Underlying Cause (Disease or injury	Nel 2	Due to (	or as a D	unswiguwno	w offi								
execute in and ial-trar	Exa	that initiated events resulting in death) Last		Due to (	or as a co	onsequence	e of):					<del></del>			
cate be executed physician and the burial-transit	Aedical Examiner			d											
certifica Iding p	n/Me	IF FEMALE: 23b. Was decedent pregna	ant 2	3c. If yes, out	come of p	oregnancy								0015. (1	
death of	sicial	in the past 12 months 1 ☐ Yes 2 ☐ No	ALIL	1 🔲 Live I	Birth 2 [ nant at tin	Fetal death		Ectopic p Other (sp		/			Ì	23d. Date of d Month	Day Year
at the d by th	Phy	9 Unknown Part II. Other significant of	conditions cor		_	not resulting	n in the w	ndedvina (	ause nive	en in Part		22a Did t		una nantributa i	to the cause of death?
uires th n signe uld be o	Completed by Physician/N											1			Probably 4 🗆 Unknown
aw req as bee	nplet								_			24a. Was			autopsy findings available completion of cause of
The licate h		05 Wes see established											rmed?	death?	
ysician s certii directo	To Be	25. Was case referred to mexaminer? 1 Yes 2 No	<u> </u>	ospital:	Innatient	2 🗆 ER/0	Outnation	- 3 🗆 no	Othe	-	ath (Check			6 X Other (Spe	Friend's
ing Phi ifter thi uneral		27. Manner of Death 1 X Natural 5 □	Pending	28a. Date		28b	. Time of injury		Bc. Injury work?	at		28d. Describe l			ecity) HOME
Attend death ctor: A	Certificate:	2 ☐ Accident 3 ☐ Suicide 6 ☐	Investigation Could not be	28e. Place	of Injury	- At home	farm stre	M et factor		∕es 2 □	$\rightarrow$	20f Location (	Ptrant or	od Alumbar av D	ural Route Number,
tal or / irs after al Dire		4 ∐ Homicide	determined		ng, etc. (S			o., 12010-y				City or Tov			urai noute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 ⊔ Me	edical Examin	er: On the bas	is of exam	nination and	or investi	igation, in r	nv opinior	n. death o	ccurred at	the time, date a	and place	and manner as	e cause(s) and manner stated
To the To the comp	2	only one) 3 ☐ Ce 29b. Signature and title of		/	to the be		iowiedge,		Irred at th		ate and pla	ce, and due to t		e(s) and manner ate signed (Mon	
now		In for	1/7	Wan	N	0				D22	775			Novemb	er 07, 2012
775		30. Name and address of p Frederick B							ue.	#130	0. CI	hevu Ch	ase	Marula	and 20815
Stat		31. Date filed (Month, Day,	2012	32. Re	gistrar's	Signatur	المداد	,			,, ,,		,	39 3	
Registra	15		<	Mary Mary	Ju.	Lycu	-								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Vincent P. Savage

State Registrar

Physician/

Medical

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

October

2012

4c. County of Death

1924

Montgomery

u.s.A.

14. Race - American Indian,

Private Business

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2012

Month

Specify:

Birthplace (State or Foreign Country)

White

Texas

10d. Inside City Limits

1 ☐ Yes 2 💢 No

MD 20904

Approximate Interval Between Onset and Death

Division of Vital Records,

λ

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 0 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D..

32. Registrar's Signature

State Registrar

DHMH 17 Rev 06-2011

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

584

1500 Forest Glen Road, Silver Spring, Maryland 20910

29c. License number

James	Charles	Scott,	Jr.	

-00376 mes Charles \$	Scot	t, Jr. State of Maryland					ible.	
		1- For State		ate of Death	id Wichtai i		1. No. 201	2 3585
Physicia edical Exami	an/	Registrar  1. Decedent's Name (First, Middle,Last)  James Charles Scot	tt Jr.			2. Date of Death Month November		3. Time of Death 0958 hrs
al and		4a. Facility Name (if not institution, give street and number) 116 S. Church Street		4b. City, Town, o Westminst	r Location of Deat		4c. County of Death	
Funeral			e (In yrs. last birth			s. 8. Date of Birth	n(MM/DD/YYYY) 9. Bird	hplace (State or
Director		218-02-7803 KM 2 F	44	Yrs. Months Day	ys Hours Mir	_	Foreig	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town of	or Location				10d. Inside City Limits
<b>E</b>	tor	MD Carroll			tminste			1 X Yes 2 No
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	10e. Street and Number 105 E. Main St., Apt.	. 2	10f. Zip Code	21157	10	g. Citizen of What Cour USA	ntry ?
death with	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?		13. Was Decedent of H If Yes, specify Cuba			White, etc.	can Indian, Black,
s after de rral", or	Š	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	No No	1 Yes 2 No		work dono	Specify: Whi	
15-0036 filed within 72 hours after 1 Hygiene. ed other than "natural", o t, the Medical Examiner is	Completed	15. Decedent's Education (Specify only highest grade com  Elementary/Secondary (0-12)  College (1-4 or 5		during most of working life  Carpenter	e. DO NOT use re		Carpentr	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	ОШО	17. Father's Name (First, Middle, Last)		Carpencer		e (First, Middle, M		
215- be filed ntal Hyg rked of	Be C	James Charles Scott	Sr.			ara Leve	_	
MD 2121(d 2 should be fill the and Mental H n 27 is marked umatic event, the	To	19a. Informant's Name/Relationship (Type, Print) Barbara L. Scott-mother		o. Mailing Address (Stre 605 Bradfo				Zip Code) 3 8 2 6 T
e, M I and 2 Health item 2		20a. Method of Disposition	20b. Place o	of Disposition (Name of co		Date	20c. Location - City or	
MOF Pages ent of unt: If		1 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:		ory or other place) cal MD Cre	em 11,	/8/2012	Westminst	er,MD
Baltimore, MD 21215 permit. Pages I and 2 should be file Departier to Health and Menta H. Important: If item 27 is marked o Injury or other traumatic event, th		21. Signature of Funeral Service Licensee	111				Funeral & nster,MD	Crematio
Physician		23a. Part . Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do no					Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (name to consider the condition of the condition)		and methado	ne)Intox	ication		Death
	<u></u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a conse	equence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
executed an and al - transit	lical Ex	d		- 00 -			S 2000 CORP	
B B B C	edic			7,28a-f,per	me,g933	11-16-1		1
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcon 1 Live birth 4 Pregnant at	ne of pregnancy 2 time of death 5	Fetal death 3	Ectopic pregr	nancy	23d. Date of deliver	/ Day Year
Box e death the atte	hysic	1 Yes 2 No 9 Unknown 9 Unknown					1	
s, P.O. Be ires that the de signed by the	þ	Part II. Other significant conditions contributing to death Cocaine Use	n but not resulting	g in the underlying cause	given in Part I.	1 Yes	bacco use contribute to	the cause of death?  pably 4  Unknown
of Vital Records, ng Physician: The law requir the this certificate has been some all director, page 2 should it	Completed					24a. Was a autops	sy prior to	topsy findings available completion of cause of
	Com					perfor 1 ✓ Yes 2	med? death? 2 No 1 ✓ Yo	es 2 No
Vital ysician: his certif director,	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatie	ent 2 FR/O	26.Place	Other Nurs		Residence 6 🗸 Othe	r Scene
n of Vision Physical After this funeral direction	n: To	27. Manner of Death  1 Netural (Month, Day,Y	ury 28b. 1		jury at Work?	28d. Describe h	ow injury occurred	
Division all or Attendi rs after death. al Director: /	icatic	Pending Investigation Accident Investigation 28e. Place of In		9:51 am 1 arm, street, factory, office	Yes 2 X No	unknows 28f. Location (S		ral Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determined (Specify)	ound in 1			or Town, St Westmins	ster,MD.	ral Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
E 3 E 3	Me	29b. Signature and title of certifier			nse number		29d. Date signed (Mo	
		30. Name and address of person who completed cause of d	teath (Item 23a)		C.M.E.		November 6, 20	1 <u>Z</u>
$\varphi$		Patricia Aronica-Pollak MD. Assistant N	/ledical Exam	niner 900 W. Balt	imore Street,	Baltimore, MI	21223	
S Regis		31. Date filed (Month, Day, Year) 32. Registra	r's Signature					

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ALEXANDER STEWART 1155 10 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HRINCE GEORGES HOSPITAL CENTER Chever Trince Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) I Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) **Funeral** Director 1 M M 2 🗆 F O Yrs 10 10-18-2012 maruland show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1) Yes 2 🗌 No Prince MD seorge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral venue 20782 U.S.A Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖎 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) None Nonenfant Vone Ivone Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ henneth amont Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) m. Stewart 38th Hehley M. S 20a. Method of Disposition Mother <u>S003</u> 20782 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1  $\square$  Burial 2 X Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 11/14/2012 Brentwood, Maryland Signature of Fun all Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MODINI 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) xtreme Medical Examiner membrane 10min Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Exami burial-tran Due to (or as a consequence of): anding physician ause as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Day Pregnant at time of death
Unknown ed by the a 9 Unknown P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No ours after death. eral Director: After this certificate h filled in by the funeral director, pag 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of title of certifier 29c. License number 10/18/2012 D56536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adeabulaque 3001 Hospital Dr MD Cheverly iled (Month, Day, Year) State Registrar

12-08369 William Sheldon

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20	12	35	85
----	----	----	----

		1- For State Registrar	Certi	ificate of E	eath		R	teg. No.				
Physicia Iedical Examir		1. Decedent's Name (First, Middle,Last) William		eldon			2. Date of Dea Month Novembe	Day Year er 5, 2012	3. Time of Death 0936 hrs			
<b>,</b>		Facility Name (if not institution, give street and number 119 Upnor Road			Baltimore	Location of Death	h 4c. County of Death					
Funeral Director		218-68-6599 tk M 2 F	218-68-6599 12 M 2 F 42 Yrs. Months Days Hours Min. 06/26/1970									
ow any		Usual Residence of Decedent  10a. State  10b. County		10d. Inside City Limits 1 Yes 2 No								
Aaryland 28a-f show 1 at once.	Director	MD n/a  10e. Street and Number	<u> </u>	altimore I	Of. Zip Code		1	10g. Citizen of What Co	Δ			
th the Maryland 23a or 28a-f sho mutified at once.	_	119 Upnor Road	U.S.A									
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ahomatic event, the Medical Examiner must be untiffed at once	Funera			If Yes,	specify Cubar	spanic Origin? ( S n, Mexican, Puerto		White, etc.	erican Indian, Black, White			
urs afte	ğ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade co	mpleted) 1		es 2 X No Usual Occupa	specify: tion (Give kind of	work done	Specify: 16b. Kind of Busines				
136 hin 72 hou e. than "na edical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	5+)		of working life ment A	DO NOT use ret	ired)	Investm	ents			
5-0036 led within 72 tygiene. nther than the Medical		17. Father's Name (First, Middle, Last)					e (First, Middle,	Maiden Surname)				
121 d be fil fental H	Be	John Walter She	eldon	10, 11, 11		Elizab			aines			
nore, MD 21215-0036 ages I and 2 should be filed within 77 int of Health and Mental Hygiene it: If item 27 is marked in ther than other traumatic event, the Medical	입	John W. Sheldon-father	8					mber, City or Town, Sta $\operatorname{sland}$ , MD				
프 연 등 점 등	- 1	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from S		ace of Disposition	n (Name of ce		Date	20c. Location - City				
Baltimore, permit. Pages 1 ar Department of Her Impurtant: If ite			"" Lii	11ton Se	erv Cor			Towson,	MD			
Bal permit Depar Impur injury		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee William	G. Dau	⊔   22. Nam ⊔   10°	e and Address	s of Facility Ruc Rd. To	k Towso	n Funeral	Home, Inc.			
Physician /Medical	-	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.							Approximate Interval Between Onset and			
Fxaminer		Immediate Cause (Final disease or condition resulting in death)  a Asphyxia  Due to (or as a const			y Diphe	enhydram	ine Into	oxication	Death			
÷		Sequentially list conditions, b										
	amine	if any, leading to immediate Due to (or as a constance. Enter Underlying Cause (Disease or injury that initiated	equence of):									
uted nd ransit	Δ̈́	events resulting in death) Last  Due to (or as a constitution)	sequence of):						12 V			
760, ficate be executed g physician and the burial - transit	Medica	x unpended AMENDED23a	,27,28	a-f,per	me,g93	33 11–16-	-12 sm					
68760, certificate be iding physici		IF FEMALE: 23b. Was decedent pregnant in the 12 months? 23c. If yes, outcomes 12 months?	me of pregna	ancy 2 Fetal	death 3	Ectopic pregn	ancy	23d. Date of deliver	ery Day Year			
Box 68' e death certifi	Physician	past 12 months?  1 Yes 2 No 9 Unknown  9 Unknown	at time of deat	h =	(Specify)							
ires that the signed by t	ē	Pert II. Other significant conditions contributing to dea	th but not res	ulting in the und	erlying cause (	given in Part I.		obacco use contribute	to the cause of death?			
ords, w require s been sig	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of										
of Vital Records, ag Physician: The law requiring the this certificate has been someral director, page 2 should la	E O	performed?   death?   1										
Vital Revysician: The his certificate director, page	Be	25. Was case referred to medical 26.Place of Death (Check only one)										
The split of the s								Residence 6 Other: Scene				
on of canding Ph ath. or: After t	텵	1 Natural 5 Pending (Month, Day)	Year)	fd 9:30 a	`   <sub>1</sub> ,	Yes 2 K No	subject took drug and asphyxiated self					
Division to or Atendi us after ceath. The Director: A	Certification:	2 Accident Investigation 3 X Suicide 6 Could not be determined (Specify)		Rural Route Number, City r Rd								
Division of Vital Records, P.O. Box 68' To the Hnspital or Attending Physician: The law requires that the death certifi within 24 hours after ceath. To the Funeral Director: After this certificate has been signed by the attending completely filler in by the funeral director, page 2 should be detached for use as	Homicide   Homicide   Residence   Baltimore, MD.											
To To	Me	295. Signature and title of certifier			29c. Licens	se number		29d. Date signed (A	ned (Month, Day, Year)			
		Yatille Polle			O.C.	November 6, 2	012					
5 of )		30. Name and address of person who completed cause of Patricia Aronica-Pollak MD. Assistant I			IOW Baltir	more Street, I	Baltimore M	ID 21223				
J perav	ate		ar's Signature			noic offeet, t	Januariore, IV					
Regist		MOTO O CUIZ LENGUA FO.	your									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:35 PM Alice A Sabella

4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Dulaney Valley Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In vrs. last birthday) Funeral Days (Month, Day, Year) Hours Director 1 M 2 92 Mar 11, 1920 New York 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No MD Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21014 United States Pump Red 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 Kino Black White etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. If Yes, Give Year or Dates 1 🗌 Yes 2 📉 No Specify: Specify: 3 Widowed 4 Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own\_Home Home Maker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unk Herbert Elsa Mobis f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21014 Alice Zuber /Daughter 907 Red Pump Rd. Bel Air. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State Nov 03 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tand 21286 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of **√**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ti signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 5:26 P M Edward Schumacher Jay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington Kensington Nurshing Home 8. Date of Birth (Month, Day, ) Nov • 2 • 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1940 New York 72 Director 056-34-0475 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State with the Maryland Director r 28a-f sh notified a 1 Yes 2 X No Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 must be Funeral items 23a 20814 United States 5508 Cornish Rd. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 1 No Specify: Specify: If Yes, Give 3 Divorced Year or Dates event, the Medical 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University / Higher Education College (1-4 or 5+) Elementary/Seconday (0-12) Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Schumacher Go1d Jules 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5508 Cornish Rd., Bethesda, MD Rebecca McCormack / Wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Durial 2 Cremation 3 Removal from State 11/05/2012 Chesapeake Crematory : Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

M K now Immediate Cause (Final ementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) signed by the a Unknown Unknown Part II. Other significant conditions confiduting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsv perform death? 1 Ves 2 No certificate 1 Yes 2 No 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 **X** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ this Vithin 24 hours after deau..

To the Funeral Director: After th Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred funeral Certificate: Natural work? 5 Pending 2 🔲 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifie

5 Main Street, Lourel, SV 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

30. Name and address of person who complete

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month Day Mae Tanner 1:15 A M Annie Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTINOPE HOSPITAL OF BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) 225-86-8919 Director 57 1 M 2 E Feb. 6, 1955 Virginia Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD Baltimore 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral anner Annie 3207 Burleith Avenue 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Medical Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Alexander Tanner, Sr. Lula Rebecca Gunn permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tory Tanner - Son 3207 Burleith Avenue Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Kentuck Bapt Ch. Cem. 11-10-12 Ringold, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral 5517 Vine St Alexandria, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ HYPOXIC BRAIN INJURY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence dry nding physician and use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ WEMORRHOIDS DIABET Records, Completed 1 Se Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No page 2 After this certificate 1 ☐ Yes 2 ☐ No of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 1 Yes 2 2 No မ 1 Management 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur@and title of certifier 29d. Date signed (Month, Day, Year) 000 mos 2401 W. Belvedere Neme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Banavah MBBS Sinai Hospital of Baltimore Baltmore MO 21215 31. Date filed (Month, Day, Year) NOV 0 8 2012 State

DHMH 17 Rev 06-2011

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month1 0 Day 27 Physician/ 11:10A M Darlene M. Taper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince Georges Hospital Prince Georges i. Social Security Number 578-96-6073 8. Date of Birth 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 47 Month, Day, Year) 8/6/1965 Washington DC **Director** 1 🗆 M 2 📑 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified MD Prince Georges Capitol Heights 1X Yes 2 No 10e. Street and Number 4904 Gunther Street 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 ŬSA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Black 0 by Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th None nt of Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last)
Charles Taper 18. Mother's Name (First, Middle, Maiden Surname) Helen Young ဂ 20743 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rocket Taper (Daughter) 4904 Gunther Street Capitol Heights MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 urial 2 🗆 Cremation 3 🗆 Removal from State Harmony Cemetery Largo, MD Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Street NW Washington DC 2007 1 21. Signature of Funer Johnson & Jenkins Funeral Home 716 Kennedy 23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Phillian/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Dav Year Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 1 Natural 5  $\square$  Pending 1 Tyes 2 🗆 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. winer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated as Practitioners. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Exy Gertifying Nu 29b. Signature and title of 29c. License number on who completed cause of death (Item 23a) (Type, Print) 30. Name and address dene

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 8 201

32. Registrar's Sig

## Baltimore, Maryland 21215-0036 Deemit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760

		For State	Please	Type or P		nd / Dep	artme	nt of H	lealth ar		-		_	jible.	2	25066	
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)  Robert Edmund Terry Sr.						tificate of Death  2. Date or Month Septe					No Day 5		35860 ime of Death ::12 P M		
Medic Examin		4a. Facility Name (if not institution, give street and number)  547 Bruce Avenue						4b. City, Town, or Location of Death Odenton				4c. County of Death Anne Arundel					
Funeral Director						(In yrs. last birthday)  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.				8. Date of Bir (Month, Da	)	Birthplace (State or Foreign Country)					
ne Maryland or 28a-f show notified at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. Ci			ity, Town or Lo	ty, Town or Location					4,	1929		New York  10d. Inside City Limits  1 □ Yes 2 □ No			
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Healith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	ral Director		MD Anne Arundel Oden  10e. Street and Number  547 Bruce Avenue					ton 10f. Zip Code 21113					1 □ Yes  10g. Citizen of What Country? USA				
	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates.					Was Decedent of Hispanic Origin? (Specify Yes or I If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2  No Specify:					Jo- 14. Race - American Indian, Black, White, etc.  Specify: White					
within 72 hour giene. er than "natul , the Medical		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)						ual Occupa ork done d se retired)	luring most o	f worki	ing	Kind of B	usiness/Ir	ndustry	unk		
d be filed Aental Hy Irked oth tic event	To Be	17. Father's Name (First, Middle, Last)  John Edmund						18. Mother's Name (First, Middle, Maiden Surname)  Beatrice Gary Pie									
nd 2 should ealth and N m 27 is me		19a. Informant's Name/Relationship (Type, Print)  Robert Terry Jr - son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 11709 Bunting Dr; Knoxville, TN 3															
Page 1 ar tment of H tant: If iter jury or oth		4 Donation	Cremation 3 5 X Other (Specif	in stat	te :e	Place of Disp cemetery, cre	matory or	other place			Date		Location -		īown, Sta	ate	
permit Depar Impor any in		21. Signeture of Funeral Service Licensee Ronald S. Wade, Director 655 W. Baltimore St; Baltimore, MD 21201												01			
Physician/ Medical		23a. Part 1. Enter the spock, or heard Immediate Cause (F disease or condition resulting in death)	t failure. List only o	olications that caus ne cause on each li a	ne.	CVA	ter the mo	de of dying	g, such as ca	rdiac o	or respiratory ar	rest,			Interva	eximate al Between t and Death	
Examiner	To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)													-		
arii e		that initiated events resulting in death) L		c. Due to (or a	ue to (or as a consequence of):												
Physician: The law requires that the death certificate be this certificate has been signed by the attending physici wal director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome of pregnancy  1									23d. Date of delivery Month Day Year				
uires that the signed by uld be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g													oute to the cause of death?		
The law rec rate has bee page 2 sho											24a. Was autoj perfo 1  Yes	psy ormed?		Were auto brior to co death?	ompletio	dings available in of cause of	
ysician: s certific director,		25. Was case referred to medical examiner?  1  Yes 2 No						26. Place of Death (Check only one)  3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other					er (Specif	iv)			
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2:	Certificate: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28a. Date of injury (Month, Day, Year) 28b. Time of injury			28c. Injury at work?			28d. Describe how injury occurred							
ital or Atter urs after de ral Directo		3 ☐ Suicide 4 ☐ Homicide	6 U Could not be determined	28e. Place of II building, 6	28e. Place of Injury - At home, farm, street, factory, offic building, etc. (Specify)				City or To				(Street and Number or Rural Route Number, own, State)				
the Hosp nin 24 hou the Funel npletely fi	Medical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											nd manner stated.				
Voith Con		29b. Signature and tipe of certifier					29	29c. License number 3				29d. Date sigged (Month, Day, Year)  11/01/2012					
			y Eugene	Lee 1132	Anna	polis	Rd #	204	0dento	n,M	① 2111	3	v				
Stat Registra		31. Date filed (Month)	V J 8 2012	32. Regis	trar's Sig	ature for	Kal										

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

barker

5601-

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY G933 11/13/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Marshall Lee Tyler 12"03 PM Tyler Lee Marchall October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 1523 Kensington Drive Hagerstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 217-32-4088
Usual Residence of Decedent **Director** 1 **X** M 2 □ F 75 Virginia Tan 16, 1937 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director must be notified 1 ☐ Yes 2 🄀 No Hagerstown Washington MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral USA items 23a 21742 1523 Kensington Dr. death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 K Married "natural", or þ Baltimore, Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) geographical map maker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucy Irene Smith Emmett Tyler 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town State, Zig Code) 1523 Kensington Dr; Hagerstown, MD 21742 19a. Informant's Name/Relationship (Type, Print) Barbara C. Tyler - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatu Funeral Service License 22. Name and Address of Facility State Anatomy Board Birector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final end- stage Ph\_sician/ congistive heart disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** cardion Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit disca that the death certificate be executed Due to (or as a consequence of) artery and attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 chronic Obstructive diabetes 1 Yes 2- No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an disease autopsy page 2 Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 
Nursing Home 5 Residence 6 
Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 5 Pending Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

Hugerstown

21740

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pal Ct.

32. Registrar's Signature

1138

MD

NOV 0 8 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 27 Physician/ 2012 5:10 РΜ Willie Turner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Thomas More Nursing Home Hyattsville Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** Sept 6, 1948 1 🛛 M 2 🗆 F Min. Washington DC Director 577-64-7307 64 Usual Residence of Decedent and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Washington 1 Yes 2 No DC 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20009 1350 R Street NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Hobbs Eddie Turner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17C Summertree Lane; Greensboro, NC 27406 19a. Informant's Name/Relationship (Type, Print) Melanie Tuner - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Spesify) In State cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board Signature of Rona Id 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at the detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 After this certificate 1 Yes 2 No . Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

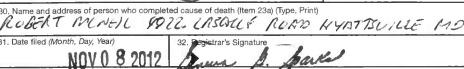
To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) NOVO 8



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year)

OCTOBER

29c. License number

172168

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G933 11/26/2012 Jh

		4	For State Of Registrar	Maryland / Dep Ce	ertificate of E		_	Reg. No. 2	12 35861
	Physicia	2/	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath = 0	3. Time of Death
-	Medic	al .	Patricia Ann  4a. Facility Name (if not institution, give street and number	Timney	The City Town on	Location of Dooth	Nov•	6 2012	
	Examin	er	Northampton Manor	1)		Location of Death		4c. County of I	
44	Funeral			Age (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9	Birthplace (State or Foreign Country)
	Director		220-38 <del>-0834</del> 1 □ м 2 □xF	71 Yrs.	Months	THOUS I WILL		9, 1941	Maryland
	show at	ō	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Le	ocation			<u> </u>	10d. Inside City Limits
	Maryla 28a-f	rect	Maryland Carroll	Westm	ninster				1 🗆 Yes 2 🗐 No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code 21157			10g. Citizen of Wha	· ·
	ath wir	nue	3809 Ridge Road  11. Marital Status 12. Was Decede	nt Ever in U.S. 13.			ecify Yes or No-		American Indian,
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If file m 27 is marked other than "natural", or items 23a or 28a-f show if filem 27 is marked other than "natural", or items 2 a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Married 2 X Married 3 Widowed 4 Divorced  Armed Force 1 Yes 2 If Yes, Give Year or Date	XNo	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 X No	Rican, etc.)	Black, V	White, etc. White	
15-0	72 hou "natu edica	plet	15. Decedent's Education (Specify only highest grade completed)	ing	16b. Kind of Busin				
121	vithin 7 iene. r than the M	Con	Elementary/Secondary (0-12) College (1-4	or 5+) life. L	DO NOT use retired) Teacher			Carroll	County Schools
pu ?	filed wall Hyg al Hyg d othe	Be (	17. Father's Name (First, Middle, Last)					Maiden Surname)	
Maryland	should be filed within 7/ and Mental Hygiene. is marked other than aumatic event, the Me	욘	Orville Hoban				ldred	Unger	
	1 and 2 sho of Health and fitem 27 is r		19a. Informant's Name/Relationship (Type, Print)  Donald E. Timney Husbar	nd 196. Mail	ling Address (Street a	load Wes	tminste	er, City or Town, State r, MD 21	
Baltimore,	permit. Page 1 ar Department of H Important: If ite any injury or oth once.		20a. Method of Disposition  1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from St  4 ☐ Donation 5 ☐ Other (Specify)		position (Name of ematory or other place arroll Cre	e) 11/2 matory	B/2012	20c. Location - Cit	y or Town, State ykesville, MD
Ball	permit Depar Impor any in once.		21. Si that we of Funeral Service Aicensee	tv Röad		etory, PA ille, MD 21784			
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each	line.			or respiratory ar	rest,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Anoxic as a consequence of:	Encephal	upnthy			Onset and Death
1	Examiner		Due to (	as a consequence of):	1	1 1			
1	_ =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):					
1/2	and -trans	xan	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or	as a consequence of):				· · · · · · · · · · · · · · · · · · ·	
B.	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	edical Examiner	d	,					
	ificate be ng physici as the bu		IF FEMALE:	-					
89 x	death certiff ne attending ed for use a	ian/l	23b. Was decedent pregnant 23c. If yes, outco	rth 2 Fetal death 3	Ectopic pregnanc	y		23d. Date of	
. Box	re dear the air ched f	ysic	1 Yes 2 No 4 Pregna 9 Unknown		Other (specify)			TVIO.TIC	<i>5</i> 4, 104
P.0	law requires that the nas been signed by the e 2 should be detach	y Pl	Part II. Other significant conditions contributing to dea	th but not resulting in the	underlying cause giv	en in Part I.	23e. Did t	tobacco use contribu	te to the cause of death?
ds,	w requires that t s been signed b g should be det	ted I					1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown
Division of Vital Records,	The law re ate has be page 2 sh	Completed by Physician/N		-				psy prio ormed? dea	e autopsy findings available r to completion of cause of th? Yes 2 \( \subseteq \) No
al	Attending Physician: The sr death. ector: After this certificate to by the funeral director, pag		25. Was case referred to medical examiner?		26. Pl	ace of Death (Chec		2 110	103 2 110
Ξ	Physic this ce ral dire	욘	1 ☐ Yes 2 No	patient 2 ER/Outpatie		4 Nursing H		dence 6 Other (S	Specify)
n o	ding F th. After funer	cate		injury 28b. Time of injury	work	/ at ? Yes 2 □ No	28d. Describe l	how injury occurred	
isio	r Atten er deal rector: by the	Certificate:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, st , etc. (Specify)			28f. Location (		r Rural Route Number,
ρj	spital o ours af eral Di filled ir		29a. Certifier 1 K Certifying Physician: To the bes		occurred at the time	e, date and place	<u> </u>		as stated.
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director After this certific completely filled in by the funeral director.	Medical	(Check 2 Medical Examiner on the basis only one) 3 Certifying Nurse Practitioner: T	of examination and/or inve	estigation, in my opinio	on, death occurred a	at the time, date	and place, and due to	the cause(s) and manner stated.
	Voite Com		29b. Signature and title of certifier		29c. License	93091		29d. Date signed (M	
	10		30. Name and address of person who completed cause		Print)			11-7	
	10		Sacred Zaidi Mn 31. Date filed (Month, Day, Year) 32. Bec	8CL *	Tou Hou	se Ave	2 Fre	derick.	MD 21701
	Sta Registra		NOV 0 9 2012	orar o digitature	1.11				

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene												
		4	For State	State of Marylan		artment of H <i>rtificate of L</i>			21	012	35865		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	Tillicate of L	Jean	2. Date of Dea	Reg. No.	J 1 (	3. Time of Death		
	Physicia		James Luther	Thwing				November 7, 2012 4:08A					
-	Medic Examin		4a. Facility Name (if not institution, give str			4b. City, Town, o	r Location of Death						
أمسه			Gilchrist Care			Towsor			Balt				
	Funeral Director		5. Social Security Number 6. Sex 198 - 22 - 2546	7. Age (In yrs. I		Months Days	Hours Min.	8. Date of Birt (Month, Da)	, Year)	Coun			
			Usual Residence of Decedent		Yrs.			Sept11	,1929		nsylvania		
	yland f sho	cto	10a. State 10b. County		ty, Town or Lo					1	10d. Inside City Limits 1		
	r 28a	Director	Md . 10e. Street and Number	I	<u>Baltin</u>	nore Cit	У		10g. Citizen of	What Cour	Δ		
	vith th		2108 Boston Str	eet Ant 30	16	212	31		•	S.A.			
	tems er m	Funeral		Was Decedent Ever in U.     Armed Forces?			lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		e - Americ			
36	within 72 hours after death with the Maryland glene. ethen "natural", or Items 23a or 28a-f sho the Madrel Examiner must be multind at	ρ	1 Never Married 2 Married	1 🔀 Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🛣 No		Thours, otoly	Specify	ck, White,			
8	atura cel E	etec	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Edu	Year or Dates.	16a. Dece	dent's Usual Occup	pation	- 0	16b. Kind of B		White		
215	in 72 h	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)		kind of work done O NOT use retired)	during most of work	ing					
2	iled with I Hygien other th	امها	12th		Cab	Driver		(F) 1 3 5 1 H			npany		
and	be file ental H ked of	일	17. Father's Name (First, Middle, Last)  John Burton				18. Mother's Nam Amber	e (First, Middle, Vroo		<i>e)</i>			
Maryland 21215-0036	2 should Ith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Numbe	r, City or Town,	State, Zip (	Code)		
	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Masical Examinar must be notified at	Ш	Dianne Bernsten				Le Avenu	e Balt	imore,	Md.	21205		
Baltimore,	t of Healt t of Healt If item 2 or other	П	20a. Method of Disposition 1 ☐ Burial 2 😡 Cremation 3 ☐ F	I Ctoto	cemeterv, crei	osition (Name of matory or other pla	<sub>ce)</sub> Nove		20c. Location	•			
Ē	it. Pag rtmen rtant: njury	Н	4 ☐ Donation 5 ☐ Other (Specify)	lBay	yview	Cremato	ory 8,2	012	Baltım	ore,	Maryland Home,PA		
Ba	permit. Page 1. Department of I Important: If it any injury or of	H	21. Signature of Funeral Service Licenses	HO	2933 2	1201 Dur	ndalk Av	e. Bal	timore	, Mc	1. 21222		
		П	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the dea							Approximate Interval Between		
- 1	hysician/	13	Immediate Cause (Final disease or condition		mic	Cor	more	op. In	7		Onset and Death		
1	Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						-r		
		jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	juence of):					-			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events										
	executed ian and urial-transit	I I	resulting in death) Last	Due to (or as a consec	uence of):								
9	ate be physic the bi	dica		l									
68760	ding l	Ž/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn					23d. D	ate of deliv	very		
Вох	Jeath c e atter d for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		□ Ectopic pregnar □ Other (specify) _	icy		м	onth	Day Year		
0.	ss that the death certificate be signed by the attending physicials be detached for use as the but	Phys	9 ☐ Unknown  Part II. Other significant conditions con	231	culting in the	underlying cause a	ivon in Part I	220 Did t	abassa usa san	tributo to t	the cause of death?		
, P.O.	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici stely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Completed by Physician/Medica	Part II. Other significant conditions con	imbuling to death but not le	suiting in the	underlying cause g	IVEITIIT CILL.			•	obably 4 🗆 Unknown		
ğ	been signal	lete						24a. Was		Were auto	opsy findings available		
Division of Vital Records,	he law te has age 2	ошо						auto perfe	psy ormed? 2 No	death?	ompletion of cause of		
<u>a</u>	ysician: The lav s certificate has director, page 2	BeC	25. Was case referred to medical examiner?				Place of Death (Chec		223,110				
Ş	Physic this ce	₽	1 ☐ Yes 2 ☑ No ☐ H	ospital: 1  Inpatient 2   28a. Date of injury	28b. Time o	ent 3 LI DOA			dence 6 Oth		y horaice		
D O	ding F th. After funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	woi		28a. Describe	how injury occur	rea			
isio	Atten er dear ector: by the	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At h building, etc. (Specia		reet, factory, office		28f, Location (		er or Rura	al Route Number,		
<u>S</u>	ital or urs aft ral Dir illed in						<u> </u>						
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Medical	(Check & Medical Examin	cian: To the best of my know er: On the basis of examination Practitioner: To the best of	on and/or inve	stigation, in my opin	ion, death occurred	at the time, date	and place, and di	ue to the ca	ause(s) and manner stated.		
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	Practitioner. To the best of	Thy knowledge	29c. Licens		lace, and due to	29d. Date sign	ed (Month,	Day, Year)		
			▶ Aron	~~		D	58303		Novem	ber	7 2012 mo		
	BX/1		30. Name and address of person who co	mpleted cause of death (Ite		Print) (5701 0	s. Clama	(4 ==	_ · · · · ·	500/	mo		
	€ Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		S DOC "		5.1	100	3010			
	Registr		NOV 0 8 2012 /	was & A	and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# The That's, G933, 1176/2012, WS

State of Maryland / Department of Health and Mental Hygiene 35866 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November Day 2, Physician/ 2012 Pauline Rosen Trasin 10:05 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Caring Companion Assisted Living Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 069-01-4705 1 □ M 2 🕅 F 98 Aug. 14, 1914 New York Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2922 Woodstock Ave. 20910 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2XXXNo Specify: Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) High School Education Teacher 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harris Dinnerstein Esther Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 Steven Rosen / Son 2922 Woodstock Ave., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory 11/05/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADVANCED DEMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying cause (Disease or Injury Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 ☐ Yes 2XXN Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No ASSISTED Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 XXOther (Specify) LIVING Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred he Funeral Director. After 1 X Natural 5 Pending injury 2 Accident
3 Suicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 2 Hedical Examiner. On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Serunying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one e and title of certifier 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 3, 2012 D52927 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE E. IGWEBE M.D.: 1500 FOREST GLEN RD., SILVER SPRING, MD 31. Date filed (Month, Day, Year) Registrar's Signature State NOV O Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 40 APA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death tiMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours Director 217-74-8889 1 XM 2 🗆 F 52 10-24-1960 MD ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1713 BOLTON STREET 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. BLACK 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4 YRS. CLERK SOC. SEC. ADMIN Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file HENRY R. THOMAS, JR. MARY POLLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other tree... 7519 HEATHERFIELD DR.. BALTO., MD 21244 HARRIET JOHNSON /SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-12-2012 BALTIMORE, MD ARBUTUS Ignature I Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC arnes a. 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ eNa 561 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 <a>D</a> Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Day ate has been signed by 1 page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy r this certificate heral director, page performed 2 🗌 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical | e 26. Place of Death (Check only one) examiner? 힏 1 Tes 2 **No** Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) thin 24 hours after death.

the Funeral Director: After this mpletely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗆 Yes 2 🗌 No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend #17618 Certificate of Death

Reg. No. 2 | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year 3:05AM Casper Vecchione Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE CLRC RAVEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb 2, 12920 Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F STCT1y Director 92 212-18-3303 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎽 No Baltimore Monkton 109. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21111 16339 Falls Rd. death 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 1943—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed 1945 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than \*\* Elementary/Seconday (0-12) College (1-4 or 5+) 11 entertainment opera singer 17. Father's Name (First, Middle Last) 18. Tropia japa (First, Middle, Maiden Surname) Roselia Terenna Antonino Vecchione 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Edgemoor Rd; Timonium, MD 21093 19a. Informant's Name/Relationship (Type, Print) Diana Amrhein - daughter Stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or 4 X Donation 5 Other (Specify) Roral d Mare, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death RENAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Records, P.O. Box in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown director, page 2 should CHRONIC KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform DEPRESSION this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 m.0 XIANGRONG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 LOCH RAVEN 31. Date filed (Month, Day, Year) State NOV 0 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and M	lental Hyg	giene (	2012	35869
Physici /Medio		1. Decedent's Name (First, Middle, Last) Saya Sol Vasquez	2. Date of Dea	Day	ZOZ	3. Time of Death
Examir Funeral Director	_	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  COULD PO  5. Social Security Number  6. Sex  1   M 20   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.    Months Days Hours Min.   Months Days Min.   Months	8. Date of Birt (Month, Da	M	9. Birthe	place (State of Foreign.
Maryland 1-f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  AUD Prince Georges  auve			1	0d. Inside City Limits Yes 2 No
eth with the 23s or 28s	rai Director	10e. Street and Number 312 Thomas Drive #4 20707		U.S.A	of What Coul	
ours after de rai', or item	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:			Black, White,	
s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. Itam 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  WKN DWN  16a. Decedent's Usual Occupation (Give kind of work done during most of works) life. DO NOT use retired)  WKN DWN	ing	16b. Kind	of Business/In	dustry
a y a la la stand a stand white and Mental Hygis marked other sumatic event,	To Be C	17. Father's Name (First, Middle, Last) Mario, Alexis, Sol Sandoval Ana	la	UYa	_, Vc	rsquez
C, IVICAL  1 and 2 sh  Health and am 27 is m  wher traum		19a. Informant's Name/Relationship (Type, Print)  Ana Laura Vasquez (Mother)  19b. Mailing Address (Street and Number or Rura 312 Thomas Dr., #4 Lau		2070	7	
Peges 1 and of He out: If Itam		20a. Method of Disposition  1 Buriar 2 Coremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory 9/2	0/2012		tion - City or To andria,	
permit. Peges Department of Important: If it any injury or		21. Signature of Fineral Service Licencee  Metropolitan Funera 5517 Vine St., Alex			2 <b>3</b> 10	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Thousand TO PNOTIC DUSPIC Due to (or as a consequence of)	C) (C)			
ted nsit	Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
te be executed ysicien and ne burial-transit	ical Exar	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):				
To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transpace.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		230	d. Date of deliv	ery Day Year
uires thet	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying sause given in Part I.  Dramuturity (27 weeks)	_	ئد		the cause of death?
ysician: The law requir sis certificate has been si director, page 2 should	Completed		24a. Was auto perfo 1 🗆 Yes		24b. Were aut prior to co death? 1  Yes	opsy findings available ompletion of cause of
Vician: /sician: S certifice	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No 150 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho			Other (Spec	rfy)
nding Phys ath. r: After this of	ation: T	27. Manner of Death  1 Action 1 Section 1 Sect	28d. Describe	how injury	occurred	
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and i wn, State)	Number or Rui	ral Route Number,
a Hospif 24 hour a Funera etely fills	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the red at the time.	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
To th within To th compl	Me	29b. Signature and title of cedifier  29c. License number  50 (00 (4)	0	29d. Date	signed (Month	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1.05 (C. Simmons 7600 Chyroll Ave	Takan	na 1	Park.	mb 20112
St Regist	ate	31. Date filed (Month, Day, Year)  31. Registrar's Signature  10. Laure B. Laure B.	Ideo	11-6-1		-112

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011

		State of Maryland / Department of Health and Mental Hygiene												
		_	1 - State Certificate of Death Reg. No. 2											
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Death November 2, 2012 9:31 P						
400	Medic	al	John Wayne		Van	Ness								
	Examin	er	4a. Facility Name (if not institution, give street and num Prince George's Hospita	,	r		r Location of Death I <b>nham</b>		4c. County of Death Prince George's					
95	Funeral			7. Age (In yrs. las		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign				
	Director		218-66-7338 1又M2□F	54	Yrs.	Months Days	Hours Min.		(Month, Day, Year) Country)					
	- MC		Usual Residence of Decedent				<u>   </u>	oury 2,	1930	Virginia				
	yland	cto	10a. State 10b. County  MD Prince George		Town or Lo	Mt. Rain	ior			10d. Inside City Limits 1 ☐ Yes ※※ No				
	e Mai r 28a notifi	Director	10e. Street and Number	5		10f. Zip Code	1161		10g. Citizen of What					
	ith th		4530 34th St.				20712		United					
	s filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show of other, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. \	Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		merican Indian,				
ဖွ	ter de , or it mine	þ	1 ☐ Never Married 2 ☐ Married Armed For 1 ☐ Yes	2 😾 No			an, Mexican, Puerto	Rican, etc.)		/hite, etc.				
21215-0036	urs af :ural"	Completed	3 ☐ Widowed 4 💢 Divorced If Yes, Give Year or Da	tes.		l Yes 2 X No			Specify:	White				
15-	72 ho "nat ledica	uple	15. Decedent's Education (Specify only highest grade completed)	ess/Industry										
12	within rgiene. ner thai	ပ်	Elementary/Secondary (0-12) College (1-12)	None										
p	iled w I Hyg othe rent,	Be	17. Father's Name (First, Middle, Last)											
Maryland	0 E 3 0	1º	John Wilbert	Hen	shaw		Emma	Jean	Ki	nzie				
lan	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)		1				City or Town, State					
	1 and 2 of Health item 27 other tr		Emma Jean VanNess / Mot				g Ct. #20		er Spring					
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from	Ctoto C6	metery, cren	sition (Name of natory or other place	ce)		20c. Location - City					
蕇	2 F F E		4 Donation 5 Other (Specify)				ory 11/0			ville, MD				
Ba	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	M0141	IK &	app Funer 33 Gist A	sal and Cally No., Silv	remation ver Spri	Services	20910				
			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on ea			Approximate Interval Between								
	Physician/		Immediate Cause (Final disease or condition	fol	el	cardiar	arri	hy there	ia	Onset and Death				
المسا	Medical Examiner		resulting in death)	or as onseque	ence out	10	. 0 .	1						
	LXummer	ř	Sequentially list conditions,		acc	ovol	abu	6 4	r	gens				
	ed nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a conseque	ence ot):	testin	al.	bleed	eu.	doep				
	be executed sician and burial-transit		that initiated events C	or as a conseque	ence of):		4	1-1	7 8	1 1				
09	ate be ex ohysician the buria	edical	d	me	the c	orgon 5	ys len	foce	we_	days.				
876	ificate ng phy as th		IF FEMALE:			/	/			•				
Box 687	eath certifice attending p	ian/	23b. Was decedent pregnant 23c. If yes, out		death 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year				
B	The law requires that the death certificate be executed attending physician and page 2 should be detached for use as the burial-trans	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregi 9 ☐ Unknown 9 ☐ Unkn	nant at time of de own	eath 5 L	Other (specify) _			WOTH	Day real				
P.O.	hat the ed by detac	by Ph	Part II. Other significant conditions contributing to de	eath but not resu	ılting in the u	ınderlying cause gi	iven in Part I.	23e. Did tol	bacco use contribut	e to the cause of death?				
s,	n sign	q pe	Depatiti	C				1 🗆 Y	es 2□No 3□	Probably 4 Unknown				
0.00	w requ	plet	hyperten	trois				24a. Was a		e autopsy findings available to completion of cause of				
of Vital Records,	sician: The law r certificate has b lirector, page 2 s	Completed	//					autops perfori 1 \(\sum \) Yes	med? deat					
ē	ysician: 1 is certifica director, p	Be C	25. Was case referred to medical examine?	/			lace of Death (Chec							
Ξ	> 00 0	은	1 No Hospital:	Inpatient 2 - E			4 L Nursing H		ence 6 Other (S	pecify)				
101	ding F h. After 1 funer	Certificate:	TENALUIAI SE Peliding	th, Day, Year)	28b. Time of injury	worl	ry at k? ]Yes 2 □ No	28d. Describe ho	ow injury occurred					
Siol	Il or Attendi after death Director: A d in by the f	ıţ[ic	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place	of Injury - At hor	ne, farm, str	eet, factory, office	res 2 🗆 No	28f. Location (St	reet and Number or	Rural Route Number,				
Division	al or A s after I Dire			ng, etc. (Specify)		, ,,		City or Town						
	To the Hospital or Attending Physician: within 24 hours after death or the Funeral Director; After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check  1 Certifying Physician: To the base of the	est of my knowle	edge, death	occurred at the tim	e, date and place, a	and due to the cau	use(s) and manner a	s stated. the cause(s) and manner stated.				
	the thin 2 the full t	Me	only one) 3 Certifying Nurse Practitioner				the time, date and p	ace, and due to th		er as stated.				
	<b>5</b> ≥ <b>6</b> 8		A All a	- M	D	230, Elochia	14534	+1 1	November.	2,2012				
	.1.		30, Name and address of person who completed caus	e of death (Item	23a) (Type, F	Print)	11	1 1	~! I					
	40		James A. A	Kras	Pri	ne Geo	rge Hos	pital	Cheverl	( MD				
	Stat Registra		31. Date filed (Month, -Day, Year) 32.	egistrar's Signatu	lire Sala	exter.	*							

DHMH 17 Rev 06-2011

Beatrice Alilkinson Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		F	Pleas amend	e Type or item 16	Pri	nt in B er fh arviance	lack In g933 Depa	delible Inl 11-8-12 artment of H	k. Ens	<b>ure A</b> and M	II Copie lental Hy	es Are	e Leg	ible.		
	_	For State Registrar				,,,,,,,		tificate of L				Reg. No	0.0	112	35	87
Physicia	n/	1. Decedent's Name Beatric									2. Date of Do Month	eath 5	20	Year	3. Time o	
Medic Examin		4a. Facility Name (if n			mber)		i	4b. City, Town, or	Location	of Death	11		. County		1:45	a <sup>M</sup>
/		Overlea						Baltim	ore		-		N/A			
Funeral Director		5. Social Security Nur 207-12-2	831	. Sex 1 ☐ M 2 <b>X</b> F	7. Age	89	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D. 12/14	rth a <i>y, Year)</i> 1/23	9. Birthplace (State or Foreign Country) VA			
laryland 3a-f show iffied at	ector	Usual Residence of D 10a. State MD	10b. County N/A			10c. City Bal	Town or Loc	or Location More								
s 23a or 2 ust be no	<b>Funeral Director</b>	10e. Street and Numb	ount S	St. #0	03			10f, Zip Code 21223				try?				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marrie 3 🏲 Widowed 4		12. Was Dec Armed F d 1 Yes If Yes, Gi Year or D	orces? 2 <b>X</b> ve		If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛣No	ın, Mexicar	n, Puerto P		-	14. Race - American Indian, Bjack, White, etc. African SpecifyAmer.			
within 72 hou /giene. ner than "nat t, the Medica	e Completed	Elementary/Secor	nday (0-12)	grade completed College (		+)	(Give k	ent's Usual Occup ind of work done of NOT use retired) OM • Eng	during mos		-	1	Seli	isiness Ind	dustry	
ld be filed Mental H arked ot atic even	To Be	17. Father's Name (Fi		st)					18. Moth Edna		(First, Middle	, Maiden	Surname	)		
ind 2 shou lealth and im 27 is m her traum		19a. Informant's Nam Lucilia	Brown		1			g Address (Street a N. Ros	edal	er or Rural e st	Route Numb					
t. Page 1 a tment of H tant: If ite jury or oth		4 Donation	☐ Cremation 3 5 ☐ Other (See		n State		netery, crem Cari	sition (Name of latory or other place mel cem	-	1/10		Bal	t.,1			
permi Depar Impol any in		21. Signature of June	eral Service Lice	ense		-	5	Name and Address 126 Bel	ss of Facilit air	Hari Rd,	P. (Balt.,	Clos MD	e F 2120	.Svs 06-5	105	
Ph <sub>e</sub> sician/ Medical		23a. Part . Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List onli inal	y one cause of	enh line		tia	r the mole of dyin	, such as	cardiac o	respiratory a	irrest,			Approxima Interval Bet Onset and	tween
executed an and rial-transit	Examiner	Sequentially list condification if any, leading to improve cause. Enter Underly Cause (Disease or iir that initiated events resulting in death) La	nediate ying njury	с. —		conseque		Mille	hus	5 7	X De					
	<u></u>	5   B														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown			Birth gnant at	of pregnance 2  Fetal ( time of de	death 3 🗌	Ectopic pregnand Other (specify)	СУ				23d. Dat	te of delive		Year
uires that the signed by all die deta	þ	Part II. Other signific	cant conditions	s contributing to	death bi	ut not resul	ting in the ur	nderlying cause giv	ven in Part	l.			-	_	e cause of coably 4 🗆	
Physician: The law req r this certificate has bee aral directór, page 2 shou	Completed											opsy formed?	, p	rior to coi leath?	osy findings impletion of c	
Ician: Tertifica ectór, p	Be	25. Was case referred examiner?		Hospital:			-11	26. Pl	ace of Dea	th (Check		200				w.U
g Physicar this ceral direction	e: 10	27. Manner of Death	No	28a. Date	of injur	у 2	R/Outpatient	t 3 L DOA   28c. Injun	y at		me 5 Res				)	
Attending or death. ector: Afte by the fun	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigat 6 Could no determine	tion of be 28e. Plac		ry - At hom	injury ne, farm, stre	M 1 D	? Yes 2 🗆	-	28f. Location			er or Rural	Route Numl	ber,
ospital or hours afte ineral Dir d filled in	Medical Ce	29a. Certifier 1	Certifying P	hysician: To the	best of	. (Specify) my knowled	dge, death o	ccured at the time	, date and	place, and	City or To	ause(s) aı	nd manne	er as state	d.	
the Ho hin 24 the Fu nplete	Med	only one) 3 [	Certifying N					gation, in my opinio eath occurred at the	e time, date			he cause(	s) and ma	nner as sta	ated.	anner stated
viit Po CO		29b. Signature and tit	le or certifier	an				29c. License	253	91		29d. Da	te signed	(Month, I	Day, Year)	
2		30. Name and addres	4AN	560	01-	-60		Raver	~ /	M	id,	Be	th	mor	e Mr	239
Stat Registra		31. Date filed (Month,	Day, Year)	012 32	Registra	r's Signatu	ha	New .								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  1 - State												
Registrar Certificate of Death Reg. No. 2012												
	Physicia	in/			2. Date of Death Month	Day Year	3. Time of Death					
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	/0	25 12 4c. County of Dear						
1	LAGITAL		MERCY MEDICAL CENTER	BALTIMORE		40. County of Bea						
	Funeral	i i	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign					
	Director		216-62-9181		July 17	1954	unk					
	and show	or	10a. State 10b. County 10c. City, Town or Loc	eation			10d. Inside City Limits					
	Maryit	Director	MD Baltimo	re			1 √ Yes 2 □ No					
	a or 2	a Di	10e. Street and Number 1021 Webb Court	10f. Zip Code	10	0g. Citizen of What Co	ountry?					
	be filed within 72 hours after death with the Maryland rental Hygiene with the state of the than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ked other than "natural" are most be notified at ite event, the Medical Examiner must be notified at	Funeral		21202	7 11	USA						
<b>.</b>	or iter	by Fu	11. Marital Status unk  1 \( \text{Never Married} \) 2 \( \text{Married} \) Married   12. Was Decedent Ever in U.S. unk Armed Forces?  1 \( \text{Never Married} \) 12. Was Decedent Ever in U.S. unk Armed Forces?  1 \( \text{Never Married} \) 13. Was Decedent Ever in U.S. unk Armed Forces?  1 \( \text{Never Married} \) 13. Was Decedent Ever in U.S. unk Armed Forces?	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit						
93	rs afte ral", Exan	ed b		☐ Yes 2 🔯 No Specify:		Specify: b	lack					
2-0	2 hou "natu	Completed		ent's Usual Occupation ind of work done during most of worki	unk	16b. Kind of Business	Industry unk					
12	thin 7	Som		O NOT use retired)								
d 2	led wi Hygik other ent, t	Be (	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	(First, Middle, Ma	aiden Surname)	unk					
lan	l be fil dental rrked tic ev	은			, ,	,						
lary	should be file h and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	g Address (Street and Number or Rura	l Route Number, (	City or Town, State, Zi	o Code)					
``	and 2 s Health tem 27 other tra			St. paul Place ba								
_				sition (Name of patory or other place)	Date 2	20c. Location - City or	Town, State					
Ħ.	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 🗓 Other (Specify) in state	Name and Address of Facility								
Ba	Depi Imp		21. Signatur of Euneral Stee cens water Virgictor St. Ronal Line Cens St. Ronal Line C	ate Anatomy Board ltimore, MD 2120	1 <sup>655</sup> W.	Baltimore	Street					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between					
P	hysician/		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ATEN CARDINAVE	LATA		Onset and Death					
	Medical Examiner		resulting in death)  Due to (or as a consequence of):									
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	red nsit	Examiner	Cause (Disease or iinjury									
	execu in and ial-tra	Exs	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
09	te be o	dical	d									
387	intifica ling pl e as tl	Physician/Me	IF FEMALE:									
×o	ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year					
œ .	he de y the iched	hysi	1  Yes 2 No 4 Pregnant at time of death 5 9 Unknown									
P.0	that t ned b e deta	y P	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?					
ds,	quires en sig ould b	ted	Human JuminodEticiENCO VIVAS (	Hir	1 ☐ Ye:	s 2□No 3 🔀 P	robably 4 🗆 Unknown					
cor	law re nas be	Completed by	HEPATITIS B VIEWS		24a. Was an autopsy	prior to	itopsy findings available completion of cause of					
Division of Vital Records, P.O. Box 687	: The cate h				perform 1 Yes 2		s 2 <b>X</b> No					
<u>ita</u>	sician certif irector	) Be	25. Was case referred to medical examiner?  1 — Yes 2 🔀 No Hospital: 1 🏋 Insertion: 2 — ED/Outpetion:	26. Place of Death (Check		- 16						
<b>_</b>	g Phy er this eral d	e: <u>1</u> 0	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	<u>me_5 ∟ Resider</u> 28d. Describe hov	nce 6 Other (Spec v injury occurred	city)					
no	ending sath. or: Aftu	ficat	1. ★ Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No								
NISI	or Atter de lirecton by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,					
٥	pital o		29a. Certifier 1. ★ Certifying Physician: To the best of my knowledge, death o	and at the time date and place on	d due to the equa	-(a) and manager as at	atod .					
1	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investionly one) 3 Certifying Nurse Practioner: To the best of my knowledge, de	igation, in my opinion, death occurred at	the time, date and	I place, and due to the	cause(s) and manner stated.					
	To the vithing to the complete		29b. Signature and title of certifier	29c. License number		d. Date signed (Mont.						
			P PIL MD	164307		10/25/20	12					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pi			.43	21201					
	Stat	e.	31. Date filed (Month, Day, Year)  32. Registrar's Signature	PAJL PL. BAL	TIMORE	MD	2127					
ļ.,	Registra		NOV 0 9 2012 1 1 1 1 1	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Huguette M. Whitehair October 2012 Medical 5:10 AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10406 Bending Brook Way Upper Marlboro Prince George's 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 □ M 2 🔀 F 395-44-6989 87 Jan 14, 1925 Yrs. France Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 10406 Bending Brook Way 20772 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ₩ Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Riganti Charles Riganti nt of Health and N t: If item 27 is ma vor other trauma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10406 Bending Brook Way; Upper Marlboro, MD 20772 Shirley Paris - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 X Donation 5 Other (Specify) Signature of Funeral Service Licensee Ronald S Wade, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 nn 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock or heart failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Securitistiv list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transi requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death 4 Pregnant a signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should CSTEMOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has 1 Yes 2 No 25. Was case referre to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident iniury 5 Pending work?
1 Yes 2 No Investigation 6 Could not be

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or Certificate: 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie: (Check 29b. Signature and title 29d. Date signed (Month, of death (Item 23a) (Type, Print)
MD - 14300 GALLAMT FOX LA# State

Registrar

amend #20state & Waryfand Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month, heresa 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban 8600 Old beorg HOSD ITa etowni Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director 6 5 1 □ M 2 🗹 F 03 -20 -196 | Washington DC of Health and Mental Hygiene. Item 23 or 28e-f show them 27 is marked other than "natural", or items 23a or 28e-f show other treumetic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehrwany fijury or other treumefin avont the state of 10b. County 10c. City, Town or Location Director Chevy Chase 1 Yes 2 No Montgomery 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 20815 4707 Chevy Chase Dr; Apt 109 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2012 Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Ellis Jon Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Coachmans Rd #8; Severna Park, MD 21146 Jon Wilson - father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial **XX** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 to Other (Specify) 111 State 11-12-2012 Hanover, MD Cremation Center 22. Namarzio I son Pomera II Chape I 6009 Harford Rd 655 W. Baltimore St; Baltimore, 121201 Signatur, of Euneral Service Icens 21214 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No or Attending Physician: after death. KATHY 25. Was case referred to medical of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ø No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined AILSON City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD al 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gairhersburg, MD 20878 127 HAllman Court Melissa Lynn Means 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35875 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 201<sup>Year</sup> 3:15 Torrey Jeremiah Wellington Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6 Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Oct Month Day, Year 12 Mjr 9 Maryland **Director** INFANT 1 XM 2 □ F Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits with the Maryland at 10c. City, Town or Location Director notified 1 Yes 2 No MD Prince Georges Clinton 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 20735 6211 Summer Suite Dr. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Examiner Armed Forces? Black White etc. 0 þ 1 X Never Married 2 ☐ Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Al Hygiene. life. DO NOT use retired) College (1-4 or 5+) INFANT Elementary/Secondary (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever မ Leonies Wellington Torrey Wellington Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6211 Summer Suite Dr; Clinton, MD 20735 Department of Health ar Important: If item 27 is any injury or other trau Leonies Wellington - mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) in state cemetery, crematory or other place) Signatu Lineral Service III n 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Phylician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner premture 105 Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death signed by the at Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? 1 Yes 2 No has 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ္ပ 1 N Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural. work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

DOO 4449

0/30/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 35876 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Julius Harry Wells October 21 9:33 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 938 N. Marlyn Avenue Essex Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral **Director** 090-36-2966 1 🛛 M 2 🗆 F 67 Oct 4, 1945 New York Usual Residence of Decedent 28a-f show 10a. State aţ 10h County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🔀 No Essex Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21221 USA 938 N. Marlyn Ave. 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No 196 If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 2 No 1966-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White permit. Page 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced 1968 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) home improvement carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Olive Christine Purcell ပ Henry John Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 938 N. Marlyn Ave; Essex, MD 21221 Amber Wells - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board **Wirector** en 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ung ('a disease or condition resulting in death) par Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of Injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death signed by the at Id be detached for 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 X ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day

person who completed cause of death (Item 23a) (Type, Print) Shoron J.

2. Registrar's Signature

38762

10-30-12

Me Comack in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 30, 2012 AMTorrez Jaylen Wellington 6:17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3<sup>Mi</sup> Oct 30, Year) Hours Director Maryland INFANT 1 🛛 M 2 🗆 F 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TV No Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6211 Summer Suite Dr. 20735 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black "natural", 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+ INFANT INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Leonies Wellington Torrey Wellington 19a Informant's Name/Relationship (Type, Print)
Leonies Wellington - mother 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zin Gode) 6211 Summer Suite Dr; Clinton, MD 20735 1 and 2 si if Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☑ Other (Specify)in state 21. Sig. 11 of Funeral Septre Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mature Sequentially list conditions Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami requires that the death certificate be executed -trar resulting in death) Last Due to (or as a consequence of) burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 2 No g Unknown Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page performed' 1 🗆 Yes 2 🔍 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 10 <u>۾</u> 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' s after death. 1 🗌 Yes 2 🗌 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOVO 8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mn

32. Registrar's Signature

00444 95

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8.000 M hrte trancis eolin Medical ity Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 10W50M 2501 If Under Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min (Month, Day, Year) Country) 1 M 2 D F 1971 Director Yrs 18 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Funeral Director 1 Yes 2 No altimor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a SA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Ö þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) anager perations traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WEDIY Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Loop Sparks )hite 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 4 Cremedion 21. Signature of Funeral Service License 22. Name and Address of Facility -letch elche E. Main 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ronal DI Jevse Immediate Cause (Final Storge Physician/ -nd disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** JUNAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine abl Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal deal in the past 12 months? Month Year Day signed by the at Id be detached for Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen s 24b. Were autopsy findings available 24a. Was an autopsy performed?

Yes 2 No this certificate has rail director, page 2 a prior to completion of cause of death?

1 Yes 2 No or Attending Physician: after death.

Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 11-07-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 2/204 OSlex 7505 FAMANT Hinary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bertram Wyatt-Brown 2012<sup>ar</sup> 12:10 A M November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 830 West 40th Street Apt. 451 **Baltimore** N/A Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 208-24-0717 1**XX**M 2 □ F 80 March 19, 1932 PA Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 West 40th Street Apt. 451 21211 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XX Married XX Yes 2 No If Yes, Give 53–55 Year or Dates. 1 Yes 2xx No Specify: Specify: White 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professor University of Florida Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hunter Wyatt-Brown Laura Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Wyatt-Brown (Wife) 830 West 40th Street Apt. 451 Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place, 11/7/12 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home. Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inderstitia resulting in death) Due to (or as a consequence of): Sequentially list conditions. cause. Enter Underlying Due to (or as a consequence oi). Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year g Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 🗌 Yes 2 🗆 No Yes 2 No 26. Place of Death (Check only one) 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Physician/ Medical Examiner

Physician/

**Examiner** 

**Funeral** 

**Director** 

notified at

28a-f

ò

items

ms 23a or must be r

ı "natural", or item ledical Examiner r

the Medical

Health and Mental Hygiene. tem 27 is marked other tha other traumatic event, the I

other 1

Department of H Important: If ite any injury or ot

Director

Funeral

þ

Completed

Be

ပ

MD

the Maryland

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical

burial-tran attending physician as the k use for detached signed by page 2 should peen director,

Exami Physician/Medical Completed by To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k Be မ filled in by the funeral Certificate:

Division of Vital Records, P.O. Box 68760

completely

DHIVIT IV Rev 00 2011

State Registrar 29a. Certifier

29b. Signatu

(Check

only one

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

suite 255. Lutherville, MS 21093 David O. noberts 1075 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NOVO 8 2012

and title of pertifie



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35880 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0 4 November<sup>D</sup> Physician/ 2012 Willem Wirtz 09:52AM Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Davs 217-18-1606 Director 1 X M 2 □ F 91 Feb. 17.1921 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notfiled at once. 10d. Inside City Limits 10c. City, Town or Location Director Lutherville 1 ☐ Yes 2 🕅 No Baltimore Maryland 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? Funeral U.S.A. 21093 515 Brightfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Amed Forces?

1 X Yes 2 No 3-1946

"Vas. Give 1943-1946 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Chief Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wirtz Johanna Helena van Gulden Willem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 Locust Avenue Ruxton, Maryland Laura G. Templeton timore, 20b. Place of Disposition (Name of Garenges Grammatonic Strip place) Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 11-15-2012 Owings Mills, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Signatu Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATOR Physician disease or condition Medical resulting in death) s a consequence of Examiner MON Sequentially list conditions, One to for as a consequence of if any, leading to immediate cause. Enter Underlying 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) 2 X No <u>۾</u> 1 Anpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) 21264 535 N. Charles ST RUSONUN 31. Date filed (Month, Day, Year)

Registrar

State

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fn, g933 11-8-12 Sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 0 Social Security Number If Under 1 Year, If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 24 Hrs. Days 213-44-8674 Director 12 M 2 □ F 67 Apr 05, 1945 Pennsylvania 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No Darlington 10f. Zip Code MD Harford ò 10e. Street and Number 10g. Citizen of What Country? Funeral 21034

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States 1979 Castleton "natural", or items Road
12. Was Decedent Ever in U.S. within 72 hours after death 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Native 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Research Scientist Huber Chemical Be Page 1 and 2 should be filed ment of Health and Mental Hyant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Glenn Sheridan Wintrode Elizabeth Margaret Hufnagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Wintrode /Wife MD 21034 1979 Castleton Road Darlington, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 07 Nov 4 ☐ Donation 5 ☐ Other (Specify) Reltsville, Maryland 2012 Chesapeake Crematory
22. Name and Address of Facility 21. Signature of Funeral Service Licensee 10 Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Onset and Death Immediate Cause (Final Physician/ RCCHON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ig physician and es the bunal-transit Exami or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 signed by the attending a be detached for use es IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 4 Pregnant at time of death 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No of Vital funeral director. 25. Was case referred to nedical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident the Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 29d. Date signed (Month, Day, Young) 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oun 31. Date filed (Month, Day, Year) 32. Registrar State NOV 0 8 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ent's Nam**e** (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 20:20 Medical ne (if not institution, give street and rumber) 4d. County of Death or Location of Deat **Examiner** non If Under 24 Hrs 8 Date of Birth 9. Birthplace (State or Foreign Sex Age (In vrs. last birthday **Funeral** Jan.3, 1949 1 M 2 F Months Hours Min. 63 Kentucky Director ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 3152 Wilkens Avenue 21223 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home б Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Delbert Thomas Cunningham Marie Gremmitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 3152 Wilkens Avenue Baltimore, MD 21223 Patricia Wiley / Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State Nov. 9, 2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 21. Signature of Funeral Service Licenses any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Cell Canier Onset and Death Immediate Cause (Final disease or condition Physician/ Squamous Medical resulting in death) Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a conse juence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 2 No Yes 2 PNc 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28h. Time of 28d. Describe how injury occurred ē Natural Pending 1 Tes 2 🗌 No Accident Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signatur ٥ MI mpleted cause of death (Item 23a) (

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760

			Plea	se Type or P							_		_	ible.	
		For State Registrar		State of I	viaiyiai		ertificate			and i	ленканту	Reg. No	20	112	3588
		Decedent's Name	e (First, Middle	, Last)							2. Date of De	eath		- L ha	3. Time of Death
Physicia Medic				antine Xin			,				Novem	ber	6, 2	<u> </u>	10:35 A <sup>M</sup>
Examin	er	22 Castl	e Hill	give street and number Court	)		Timo	nium	Location	of Death			County of Calti		
Funeral Director		5. Social Security No. 218-78-7 Usual Residence of	683	6. Sex 7 1 X M 2 □ F	Age (In yrs. I	ast birthday) 54 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bit 5/8/19	rth 34 (Sea <i>r)</i> 58		9. Birthplace (State or Foreign Maryland	
faryland 3a-f show iffied at	Director	<sup>10a. State</sup> Maryland	10b. County Balti	more		y, Town or L onium	ocation						'	1	10d. Inside City Limits 1 ☐ Yes 2 No
with the N 23a or 2 ist be no	eral Dii	10e. Street and Num 22 Cast1		Court			10f. Zip	Code 1093				_	s.A.	/hat Cour	ntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1  Never Marri 3  Widowed		ied 12. Was Deceder Armed Force 1	s? <b>X</b> No	S. 13.	Was Deced If Yes, spec	ify Cuba	n, Mexicar	ı, Puerto	ecify Yes or No- Rican, etc.)	-	e - Americ k, White, Whi		
hours natur dical l	lete	/2==		t's Education	•		edent's Usua			4 = 6 = ele	ina	16b. K	Kind of Bu		
within 72 /giene. ner than " t, the Med	e Completed	Elementary/Seco		st grade completed)  College (1-4 o	or 5+)	Ìife. L	kind of wor DO NOT use Engin	retired)				Res	earcl	h & 1	Development
ld be filed Mental Hy arked ott	To Be	17. Father's Name (I									e (First, Middle, Christi		Surname,	)	
shou h and 7 is m traum	P	19a. Informant's Na					-				al Route Numbe				
and 2 Healtt tem 2		Constant 20a. Method of Disp		ntas / fath		4545 Place of Disp			BLVC		15D Bo			~	33431 own, State
it. Page 1 rtment of rtant: If i		4 Donation	5 Other (S		to   0	<ul> <li>Deme</li> </ul>	ematory or o	ther place Cem	ı <b>.</b> [1	1/9,	/2012	Bal	timo	re, l	Maryland
permir Depar Impor any in	B	21. Signature at Ju	M	1a/mi	i	1	.050 Y	ork	Road	ToT	wson, M	aryl			me, Inc. 4
h, i i Medical Examiner	er	shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List o Final n	b. ———	ine.	uence of):	'			- 1	D S	Se <i>G</i> 2	SQ.		Approximate Interval Between Onset and Death
cate be executed physician and s the burial-transit	edical Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	injury S												
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcor 1  Live Birt 4  Pregnar 9  Unknow	h 2 ☐ Feta tattime of∢	al death 3	☐ Ectopic p ☐ Other (sp		у				23d. Date Mor		ery Day Year
requires that the dea	by	Part II. Other signif	icant conditio	ns contributing to deat	but not res	sulting in the	underlying o	ause giv	en in Part	l. 					ne cause of death?
sician: The law requ certificate has beer lirector, page 2 shot	Completed	01									24a. Was auto perfe 1 \(\sum \) Yes	opsy ormed?	p d		psy findings available mpletion of cause of
cian: ertifica ector,	Be	25. Was case referre examiner?	ed to medical	Hospital:				_		th <i>(Chec</i>	k only one)				
Physicia r this cert aral direct	일 ::	1 Yes 2 27. Manner of Death		1 ☐ Inp		ER/Outpatie		Othe Bc. Injury	4 □ N		ome 5X Resi 28d. Describe				2
nding Fath.	icate	1 Natural 2 Accident	5 Pendin	g (Month, i	Day, Year)	injury	M	work			Edd. Describe	now injur	y occurre	u	
al or Attend s after death il Director; /	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determine	28e. Place of	njury - At ho etc. (Specify		reet, factory	office			28f. Location ( City or Tox			r or Rural	Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 (Check 2	Medical E	Physician: To the best xaminer: On the basis of Nurse Practitioner To	f examination	n and/or inve	stigation, in r	ny opinio	n, death o	curred a	t the time, date	and place	e, and due	to the car	use(s) and manner stated
To t with To tl		29b. Signature and	title of certifier	MD De	puti				number				ite signed	V .	
61	<	30. Nam and addre	ess of person v	who completed cause o	death (Ital	1 ( )	Print)	T. Lis	thon	,:(1.	e Md	210	97	3	6,2012
Stat	te	31. Date filed (Monti	h, Day, Year)	32. Regi	trar's Signa			<b>Y</b>			1	-,-			

DHMH 17 Rev 06-2011

		A	Pleas MEND #26, PER VER	Se Type or Print in	Black Inde	lible Ink. Ensure	All Copies	Are Legible	•
		•	For State Registrar		Certific	cate of Death		g. No. 2 1	2 35884
	Physicia Medic		1. Peredent's Name (First, Middle, Kaymond	C. Young			2 Date of Death Month CTO C	29,2012	3. Time of Death 5:28/P M
	Examin	er	4a. Facility large (if not institution, o	t Valley Dr	ive (	Town, or Location of Deat	e	4c. County of Dea	more
	Funeral Director		5. Social Security Number 190-20-7524  Usual Residence of Decedent	7. Nde (In yrs.)	Ast birthday) If U Mon	nder 1 Year   If Under 24 Hrs ths Days Hours Min.		927 9. Bi	rthplace (State or Foreign buntry)
	Maryland 28a-f shov	rector	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with tha	Funeral Director	10e. Street and Number alver	ton Heights	10	21216	10	og. Citizen of What Co	ountry?
9036	1 end 2 should ba filed within 72 hours after daath with tha Maryland of Health and Mantal Hygiene. itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinet cust be rediffed at	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces?  d 1	If Yes,	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puer es 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 hou giene. ner than "nat t, the Medica	e Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4 or 5+)	Give kind or	Usual Occupation f work done during most of wo f use refred)  MSPECT	rking 1	6b. Kind of Business	Motors
yland	should ba filad and Mantal Hy 7 is marked oth raumatic event	To Be	17. Jamen's Name (First Middle, Lat	t Young		1 /1.		aiden Sumame) 9 Mian	)
	end 2 shou Health and am 27 is m ther traum		19a Informant's Name/Relationship William Lewis	Nephew	10001	ress (Street and Number or Ri	ey Dr,		11e, MD
Baltimore,	permit. Paga 1 e Department of F Important: If its eny injury or ot		20a. Method of Disposition  1 D Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Sp.	☐ Removal from State	Place of Disposition cemetery, crematory		3/12	Oc. Location - City or Baltimo	Town, State
Bai	permit Depar Impor eny th		21. Signature of Funeral Bervice Lic	C. Greene	- 515	Ress of Ability C	reene fi t'  Pil	e (212	Services 29)
31	Priysician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	omplications that caused the deat y one cause on each line.	9	W 11			Approximate Interval Between Onset and Death
	Medical Examiner	<u>.</u>	resulting in death)  Sequentially list conditions,	Due to (or as a consequence of the consequence of t	nd cas	tration-re	·		14mos
	axecuted an and riel-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o					
09/			resulting in death, cast	d	uerios ori.				
<i>0 € − 2ℓ</i> Records, P.O. Box 68760	e daath cartificata ba tha ettanding physicis chad for usa as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1	al death 3 🗌 Ecto			23d. Date of de Month	livery Day Year
S,(P.O.	aquiras that the da than signed by tha should ba datachad	d by Ph	Part II. Other significant conditions	s contributing to death but not res	sulting in the underly	ing cause given in Part I.			the cause of death?
ecord	e law naqu e has baar nge 2 shou	mplete	/				24a. Was an autopsy perform	24b. Were au	topsy findings available completion of cause of
2 R	sician: The la cartificate ha lirector page 3	Be C	25. Was case referred to medical examiner?			26. Place of Death (Che	1 □ Yes 2	Ño 1 ☐ Ye	s 2 🗆 No
\$ ₹ ¥ 5	Attanding Physician: or daath. octor: Aftar this cartific by tha funerel director	ᅀ	1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of injury	ER/Outpatient 3 28b. Time of			NEPHE ce 6 🖾 Other (Spec	RESIDENCE
o co	ath. r: Aftar ra fune	cate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigat	(Month, Day, Year) ion	injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director After this cartificate has I complately filled in by the funeral director page 2 somplately filled in by the funeral director page 2.	al Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ome, farm, street, fac	ctory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire complataly fillad in b	Medical	(Check 2 L. Medical Exa	hysician: To the best of my know miner: On the basis of examination urse Practitioner: To the best of r	n and/or investigation	<ul> <li>in my opinion, death occurred.</li> </ul>	at the time date and	place and due to the	rausels) and manner stated
	Vithir To th	2	29b. Signature and title of certifier	1) Company	Try Knowledge, death	29c. License number	296	d. Date signed (Monti	n, Day, Year)
•			30. Name and address of person wh	o completed cause of death (the	239) (Time Drint)	D42979 MICH	0	007 3	2012
			401 North	Broadway 1	Balhm	ore MD MICH	THEL CA	HEDUCCI	ΜD
	Stat Registra	_	31. Date filed (Month, Day, Year)	2012 32. Registrar's Signar	Balhman tury	N			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pu Su Yi 2012 1:20a M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wheaton Montgomery Randolph Hills Nursing Home Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days (Month, Day, Year) 01/19/1918 94 **Director** 231-35-1573 Korea Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Wheaton 1 X Yes 2 No Maruland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 U.S.A. 4011 Randolph Road within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Asian Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seung Bok Yi Ke Sun Yun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chong Hyon Mun - Daughter 20820 Scottsbury Drive. Germantown, Maryland 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Lincoln Crematory 11/14/2012 Brentwood, Maryland Signature of Funeral Service bicensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland Ranny 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as f attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þ Hypertension 1 Yes 2 No 3 Probably 4X Unknown page 2 should peen Diabetes Mellitus Type 2 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 X No this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident within 24 hours after des To the Funeral Directon completed filled in by th Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 03, 2012 D52261 th (Item 23a) (Type, Print) 30. Name and address of person who completed cause of de-1517 Hugo Circle, Silver Spring, Maryland 20906 Alan R. Segal, M.D..

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Young 2012 1:30 AM Mildred November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 577-16-7866 Director 1 [] M 2 🗓 F 97 Yrs. Maryland June 20,1915 ms 23a or 28a-f show must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 Yes 2XXNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 United States 2500 Briggs Chaney Rd. 27 is marked other than "natural", or items traumatic event, the Me ical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Mail Room Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Edgar Murphy Daphney (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20905 2500 Briggs Chaney Rd., Silver Spring, MD Mildred Young / Self Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 11/12/2012 Union Cemetery Burtonsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ BREAST CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed Yes 2XX 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRAH MILLER, CRNP, 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20855

DHMH 17 Rev 06-2011

State Registrar

68760

			-	Please	Type or Pr AMEND I State of M AMEND #27	int in TEM#2	Black ZperF	Indeli H, G9	ble Inl	k Ens	ure A	II Copie	s Ar	e Leg	ible.		
		_	For State Registrar		AMEND #27	, PE	R MDC	3933 ertifica	11 /8 / ate of L	12 TR Death	AT	icinai i i,	Reg. N	o. 21	112	3 =	887
	Physicia	ın/		e (First, Middle, Las	t)							2. Date of De	eath	ay	Year	3. Time of	Death
	Medic Examin	al_	Mary 4a. Eacility Name (if	lee Zeile not institution, give		2		4b. C	tv. Town, or	r Location o	of Death	OCTOBE	R 1	2) 2	of Death	2.08	М
	<u>)                                    </u>		SAINT :	JOSEPH,	MEdiCAL		NfeR			OU	150	on!		131	711	, MOX	eE
	Funeral Director		5. Social Security No. 216-28-1		9X 7.Ag □ M 2X F	ge (In yrs.	last birthday Yrs.	) If Un Month	der 1 Year is Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)		9. Birthp Coun	olace (State o try)	or Foreign
		_	Usual Residence of				ty, Town or I					Apr 2	0, 1	931		land	
	farylan 8a-f sh tified a	Funeral Director	MD	Baltimo	re		imoniu								,	0d. Inside Ci	ty ⊔mits 2 1√2 No
	h the h la or 21 be no	al Dir	10e. Street and Nun	nber		1	211101121	_	Zip Code				10g. C		Vhat Cour	itry?	
	ath wit sms 23 rmust	uner	2300 Du	laney Val	.ley Road	Ever in 11	S 112	Was Dev	edent of H	210		cify Ves or No			SA	an Indian	
4/ee C 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumetic event, If a Medical Examiner must be notified at once.	by		ied 2 🖾 Married 4 🗌 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	2	.5.			Specify:		cify Yes or No Rican, etc.)		Blac	e - Americ k, White, c whit	etc.	!
15-6	72 hou n "nat	Completed		15. Decedent's Ed ecify only highest gra	de completed)		(Giv	e kind of v	sual Occup vork done o use retired)	ation during most	t of workii	ng	16b.	Kind of B	usiness/Ind	dustry	
25	l within /giene. ner tha t, the l	Col	Elementary/Second 12	indary (0-12)	College (1-4 or 2	5+) 	lire.		etary					past	ora1	care	
MAR	uld be filed Mental Hy narked oth	To Be	17. Father's Name (I Jack Co	ttrell			-			Do	roth	y Retta	alia	ta			
Mary	2 should lth and Me 27 Is marl r treumeti			me/Relationship <i>(Ty</i> Zeiler/sp								Route Number					
e/e/	of Hea of Hea if item r other		20a. Method of Disp				Place of Dis	nosition (A	lame of	<del>-</del>		ate			City or To		
$ZE/\lambda eR$ Baltimore,	It. Page rtment rtant: I njury o		4 ☐ Donation	5 [X] Other Specify	)	ME	IRO	CZEI	MATO	RY		17/12				. M.	71212
Bal	permit. Departr Imports any Inju		21. Signature Fu	al Servic Licens	jo, gir	ecto	_ 17	Charles Service	and Addres			hell-W	-	ZIZ	re S	treet	
		4	23a. Part 1. Enter to shock, or hear	he disease, or comp t failure. List only or	olications that cause ne cause on each lin	d the deal		- DE 1		7 1717		71				Approximat Interval Bet	e ween
78	Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a CAR	DIA	10	AR.	K/+	411	4M,	A			3	Onset and I	Death
-	Examiner		Sequentially list con	nditions	Due to (or as	a conseq	uence ot):										i
F	ed issit	Examiner	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i	rlying	Due to (or as	а сывец	dence of).									<del>-</del> -	
1	executed ian and irial-transit	Exa	that initiated events resulting in death) I	3	C. Due to (or as	a conseq	uence of):									<u>-</u>	
09/	ate be physicia the bu	dica			d												
687	certific nding puse as	ın/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome									23d. Dat	te of delive	erv	
-2   Records, P.O. Box 68760	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Other	c pregnanc (specify)	;y 				Мо	nth	Day \	/ear
P.O.	that the	by Ph	Part II. Other signifi	icant conditions co	intributing to death t	out not res	sulting in the	underlyin	g cause giv	ven in Part I	l.	23e. Did	tobacco	use contr	ibute to th	e cause of d	eath?
ds,	equires sen signould by						_					1 🗆	Yes 2	X100	3 🗌 Prot	ably 4 🗌	Unknown
	has be ge 2 sh	Completed										24a. Was		, ,	Vere autor prior to cor death?	sy findings a npletion of c	available ause of
_	ding Physician: The law h. After this certificate has funeral director, page 2	Be Co	25. Was case referre	ed to medical					26. Pla	ace of Deat	th (Check	1 \( \text{Yes}			☐ Yes	2 🗆 No	
Vit.	hysici his cer al direc	유	examiner? 1 Xes 2	J 140			ER/Outpati		Othe	ar.	·	me 5 ☐ Resi	idence	6 ☐ Othe	r (Specify)		
<u> </u>	iding F th. After t	cate:	27. Monner of Death  1 X Natural  2 ☐ Accident	5 Pending	28a. Date of inju (Month, Da	ury y, Yea <i>r)</i>	28b. Time injury		28c. Injury work ₁ □		- 1	8d. Describe	how inju	ry occurre	ed		- 1
† Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicicompletely filled in by the funeral director, page 2 should be detached for use as the by	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e Place of Ini	ury - At ho	ome, farm, s			103 2 1	-	28f. Location ( City or To			r or Rural	Route Numb	er,
۵	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1	Certifying Phys	ician: To the best of	mv know	ledge, death	occurred	at the time	date and	place an	d due to the o	ause(s) a	and mann	er as state	vd	
	the Ho nin 24 h the Ful npletely	Medical	only one) 3	☐ Medical Examin	ner: On the basis of e	examinatio	n and/or inve	estigation,	in my opinia	on, death oc	curred at	the time, date	and place	<ul> <li>e. and due</li> </ul>	to the cau	ise(s) and ma	nner stated.
	o o vitt		29b. Signature and t	, 0	rpade		20	2	9c. License	number	22			ate signed	(Month, E	-	,
	(6)		30. Name and addre		/	death (Item	n 23a) (Type	Print)	76	000	0	, –	-		10/	201	
	4		NEE TA 31. Date filed (Month	DEST	PANDE 32 Registr	M.	D., 70	001	056	er D	Rive	= 10	WS	ON, 1	MAR	YLAND	21204
	Stat Registra			iny 0820	12 Gregistr	ar's Signa	S. A	all	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ ZIEM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Shady Grove Adventist Hospita 9108191 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 🛛 M 2 🗆 F Months Min. Director INFANT Usual Residence of Decedent 28a-f show 10b. County 10c, City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director Rockville Montgomery 10f. Zip Code 10e. Street and Number 20877 12 O'Neil Dr Apt 4 Funeral Z:cm 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates Juliennt 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-40V5 INFANT Be 17. Father's Name (First, Middle, Last) Louis Nana Tchuimeni 19a. Informant's Name/Relationship (Type, Print) Julienne Ziem — mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cother (Specify) in state 21. Signature of uneral Service to se Director 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final extreme Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ture rema Sequentially list accelera-if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (pr as a consequence of): burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed 25. Was case referred to medical examiner? Division of Vital Be 1 ☐ Yes 2 🛱 No ဂ္ 1 🖼 Inpatient 2 🗌 ER/Outpatient 3 🔲 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

990

Jillian Loliano, MD

31. Date filed (*Month, Day, Year)* **000 8 2012** 

18. Mother's Name (First, Middle, Maiden Surname)
Julienne Ziem 19b. Mailing Andress (Street and Number of, Rural Route Number, City or Town, State, Zig 6309) 7 20c. Location - City or Town, State 22. Name and Address of Facility State Anatomy Foard 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23d. Date of deliven Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 7 N prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) Rodwille medical center Drive,

2. Date of Death

8. Date of Birth

octonthopay, Year) 12

10

19:35 PM

2012

omer

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 H No

Maryland

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc

Specify: Black

16b. Kind of Business Industry

INFANT

Monta

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 16. Physician/ Porfirio Archila 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Regional Hospital rince Laurel -aurel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 83 4<sup>M</sup>/7/1<sup>x</sup>929 El<sup>country</sup>lvador 218-19-9448 1 🏝 M 2 🗆 F Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be, ngiffied at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Beltsville MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20705 3603 Cherryvale Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc. Š 1 Never Married 2 Married Fl Salvadoran Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Buildings Maintenance Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္က Concepcion Archila Victor Escobar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Cherryvale Drive Beltsville, Md 20705 Sonia Bonilla/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 M Burial 2 Cremation 3 Removal from State George Washington10/20/2012 Adelphi.Md 4 Donation 5 Other (Specify 21. Signature PHTETPAGERTWALDI FUNERAL SERVICE, PA 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heak failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary yedrs disease or condition Medical resulting in death) **Examiner** pertension *yedrs* Sequentially list conditions, Examine cause. Enter Underlying Mellitus I Diabetes Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed redrs attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Failure, Gangrene Leg 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen : Pneumonia, 24b. Were autopsy findings available prior to completion of cause of death? Aspiration 24a. Was an page 2 s has performed? Yes 2 No within 24 hours a er decth.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \( \subseteq \text{Yes} Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No ٥ 1 X Inpatient 2 DER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 X Natural 5  $\square$  Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: Of the basis of examination and of infooting attention and of the cause (s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

Year!

19 2012

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Pritam S, Saini MD 9101 Cherry La

Cherry Lane, Suite 211

D28998

Laurel,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 8:00 A FRANKLIN ROOSEVELT ABRECHT, JR. October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 302 Adam Rd. Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 9, 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 🖾 M 2 🗆 F Days Hours Min. ື່ 1955 Director 215-64-1308 57 WV Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 Adam Rd. 21701 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No 72 hours after 1 Yes 2 No Specify 3 Divorced If Yes, Give Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 data processor assistant banking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill of Health and Mental fitem 27 is marked 2 Franklin R. Abrecht, Sr. Myrtle Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lark Abrecht/wife Adam Rd., Frederick, MD 21701 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 01ivet vet 10/19/12 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 10/19/12 21. Signature of Funeral Service 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter tile dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find Physician/ tars disease or condition Medical resulting in death) sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or linjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year signed by the a 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No page death? certificate 2 🗌 No 25. Was case referred to medical examiner? funeral director, æ 26. Place of Death (Check only one) 2**X** No Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending I thin 24 hours after death. the Funeral Director: After 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) PU. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bus cric

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registrar's Signature

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Phonosthmant of Hasilth and Martial Honliene. Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Division of Vital Records, P.O. Box 68760

			Plea	ise Type oi							-		gible.		
		For State Registrar		State	of Mary	land / [	•	artment of F tificate of L		nd N		iene <sub>eg. No.</sub> 2	0	2 35891	
Physicia Medic		1. Decedent's Name Leland									2. Date of Deat Month 10	Day 18	Ž <b>T</b> 1	3. Time of Death 7:55 A M	
Examin		4a. Facility Name (if Riderwo		give street and nui	mber)			4b. City, Town, or Silve	Location of r Spri			4c. Count	y of Deat ntgor		
uneral irector		5. Social Security N 224-52-4	259	6. Sex 1 M 2 D F		rs. last birti 39	hday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. Min.	8. Date of Birth (Month, Day, 2/7/19)	Year)		thplace (State or Foreign untry)	
show	or	Usual Residence of 10a. State	of Decedent 10b. County		100	. City, Towr	n or Loc	ation						10d. Inside City Limits	
28a-f otifiec	irect	MD		nce Georg	e			Silver S	pring					1 ☐ Yes 🍇 No	
3a or t be n	Funeral Director	10e. Street and Nun		1 D 1	Da 100			10f. Zip Code	,		1	Og. Citizen of		ountry?	
ems 2	nne	3160 Gra	ceriero	12. Was Dec	RC 130 edent Ever in		13. V	2090 Vas Decedent of H	ispanic Origin	n? (Spe	cify Yes or No-	14. Ba		erican Indian,	
Department or result and wentar hygens.  Department or result and wentar hygens.  By any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Marr		ried XX Yes If Yes, Gi Year or D	2 🗌 No ]	1941 <b>-</b> 1961	If	Yes, specify Cuba	ın, Mexican,	Puerto I	Rican, etc.)	Bla	Black, White, etc. Specify: White		
an "natu Medical	Completed	(Spe	cify only highe	nt's Education est grade completed		16a.	(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most o	of workir	ng	16b. Kind of E	3usiness/	/Industry	
ygrene her th it, the	Be Co			College (	1 101017		Сс	mputer P				NSA			
ked ot	To B	17. Father's Name (I		,							(First, Middle, N Ellen M		ne)		
sma mar		19a. Informant's Na				19b	. Mailin	g Address (Street					State, Zij	p Code)	
m 27 is			William Anderson Son 51 Sheridan RD. Arnold, MD 21012  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City												
ant: If ite		20a. Method of Disp 1 <b>XX</b> Burial 2 4 Donation		Town, State											
Import any inj		21. Signature of Fu	peral Service L	icense	•			Name and Addres			-			e, P.A.	
sician/		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or conditio			Approximate Interval Between Onset and Death										
Medical aminer	_	resulting in death)	nditions		monia (or as a con	sequence o	of):			-					
ransit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	imediate Iying injury	Due to	(or as a con	sequence o									
nysician ar he burial-t															
To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 🗆 nant at time	Fetal death		Ectopic pregnanc	Sy				ate of de	livery Day Year	
ned by e deta	by Pł	Part II. Other signif							ven in Part I.					the cause of death?	
sen sig rould b	ted	Atherosc	lerotio	c Cerebro	vascu]	lar D:	isea	ise			1 □ Y€	es 2 No	3 🗆 P	robably 4XXUnknown	
ate has b page 2 st	Completed										24a. Was ar autops perforr 1 \sum Yes	ned?	prior to death?	ntopsy findings available completion of cause of s 2 □ No	
ector,	Be	25. Was case referre examiner?		Hospital:					ace of Death	(Check	only one)				
rthis c eral dir	은 일	1 ☐ Yes 2X 27. Manner of Death	<b>X</b> No	1 28a. Date		1	itpatien fime of	t 3 DOA Othe	4 <b>X X</b> Nurs		me 5 Reside			oify)	
tor: After	Certificate:	1 🛣 Natural 2 □ Accident 3 □ Suicide	5 ☐ Pendin Investion 6 ☐ Could	g (Mor	nth, Day, Yea	r) ir	njury	M 1	Yes 2 \( \simethins 1	No					
ral Direc		4  Homicide	determ	build	ing, etc. (Sp	ecify)		et, factory, office			City or Town	, State)		ral Route Number,	
he Fune pletely fi	Medical	only one)	Medica	Physician: To the l xaminer: On the ba Nurse Practitione	sis of examir	nation and/o	rinvest	igation, in my opinio	on, death occ	urred at	the time, date an	d place, and di	ue to the	cause(s) and manner stated.	
<b>T</b> O 0		29b. Signature and	itle of dentifier	L			29c. License D2403			2	9d. Date signe				
44		30. Name and addre		who completed cau				,	20904	4				<del>-</del> -	
Stat Registra		31. Date filed (Monti	Day Year		Pogistrovio Ci	apatura		bart							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month / U Day 1602PM 6 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 82 Director 052-22-4134 1 XM 2 □ F July 29,1930 New York items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 51 Arundel Beach Road USA 21146 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give filed within 72 hours efter 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Research Science Consultant 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ٩ Page 1 and 2 should be Carrie Wolf Edwin Walters Albers Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Ed Albers, Jr. / Son 126 Westside Drive Rehoboth Beach, DE 19971 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 18, 20c. Location - City or Town, State Department of Important: If II any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. Metro Crematory, Baltimore, MD INC: 2012 21. Signature of Europeal Service Licenses 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HBP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be execute, within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 - No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes ၉ 2 🖸 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 28686 Victor Playner completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Ũ 2101 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35893 State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ann Sylvanie Aubain 0132A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MEDICAL Centu NICOMICO PENINSULA SALISBURY 6. Sex Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) Director 1 🗆 M 2 🗓 F 580-16-7840 89 b8|24|1923 St. Thomas, US VI Usual Residence of Decede show 10a. State 10b. County filed within 72 hours after death with the Maryland ir than "natural", or Itema 23a or 28a-f sho The Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Saint Thomas St. Thomas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 00802 USA Contant 7B 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give <u>چ</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Domestic mit. Page 1 end 2 should be filed with partnent of Health end Mentel Hygler partent: If item 27 is marked other terlinjury or other treumatic event, In Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosita Turbe Eugen Greaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 N. Kaywood Dr., Salisbury, Maryland 21804 <u>Irene Aubain daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖺 Burial 2 🗌 Cremation 3 🗍 Removal from State Western Cemetery 3 10 24 2012 St. Thomas, US VI 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funera S rvice Licensee 22. Name and Address of Facility
HOLLOWAY Funeral Home P.A. aria A. Domprox Snow Hill Rd., Salisbury, Maryland 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Exami gned by the ettending physicien and be deteched for use es the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2,2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate hes been significate hes been significated functions and a should 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Tes Accident Investigation 2 🗌 No after deeth Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a edical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) MI D-71972 18/12. 30. Name and address ho completed cause of death (Item 23a) (Type, Print) of person MD HB10 SHAIK 951 Mt. Hermon Rd ABDUL 2180 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 19 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Adkins W. 2012 4:10 AMM Rosetta October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Min. Hours Director 220-10-8381 1 M 2 X F 92 3-27-1920 Maryland Usual Residence of Decedent pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any liping or other traumatic event, the Medical Examiner must be accepted. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31256 Shavox Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by Adkims Apsente Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Seamstress Shirt Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Webster Addie Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Richter - Nephew 1810 N. Mill Drive, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Parsons Cemetery 10-18-2012 Salisbury, Maryland 21. Signature Fundral Service Licen 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatu Bran- Cancer disease or condition resulting in death) 5461K Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed To the Hospital or Attending Physiclen: The law requires that the death certificate be executer within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deficing rijections in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Inha Nahun D051359 October 15 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415. S. DIVISION ST, SALISBURY, MD 21804 DR. USHA NATESAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gloria Jean Bentley October 0 2012 12:00A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20915 Governors Mill Court St. Mary's **Great Mills** Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) '. Age (In vrs. last birthday) **Funeral** Days Hours 213-82-2735 **Director** 1 🗆 M 2 🕱 F 73 10/09/1939 Usual Residence of Decedent **Maryland** 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No Maryland St. Mary's **Great Mills** 10f. Zip Code ò Street and Number 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 20915 Governors Mill Court 20634 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 Hygiene. other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumation once. မ Ellen M. Lane Carl F. Lettau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde T. Bentley/ Husband 20915 Governors Mill Court Great Mills, MD 20634 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State ce Mactingley cardiner 4 Donation 5 Other (Specify) Funeral Home, P.A. Crematory 10/27/2012 Leonardtown, MD Sign turn of Funeral Service Linus Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fh. sician/ all bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): 7 months Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 ding IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe ( 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Yes 2, No 1 ☐ Yes 2 🗷 No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify after death. 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day. Year) D 68120 10-23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (5) Rme 23415 Three Notch Rd., CAlifornia, MD 20619 Minal M. Shah

State Registrar 31. Date filed (Month, Day, Year OCT 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charlynn Louise Brown 100 05 / 2012 10:19 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours (Month, Day, Year) 5/29/1942 Director 216-84-7994 1 □ M 2 □X€ 70 Usual Residence of Decedent 28e-f show I Hygiene. other than "netural", or items 23a or 28e-f shovent, the Madical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Irector 10d. Inside City Limits Washington, DC 1 Yes 2 No ᅙ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7035 Blair Road NW #102 20012 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🛛 No Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled disabled 17. Father's Name (First, Middle, Last) should be fillar end Mantel H is marked ot 18. Mother's Name (First, Middle, Maiden Surname) UNK Marion Brown <sup>19a.</sup> Informant's Name/Relationship (Type, Print)
Patricia McDonald-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 of Heelth e 11006 Viers Mill Road, L15-363 Wheaton, Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Paga 1 e
Departmant of H
importent: if ite
eny injury or oti 20c. Location - City or Town, State Date 10/26/12 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W.H. Bacon Funeral Home Warda C. Bacon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, fary leading to infractionate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physicien: The lew requires that the deeth cartificate be exacuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlal-transit. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မှ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0

22

Padmaja Bandi

OCT

MIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 Carroll

D0068026

Ave Takoma Park.MD 20912

29d. Date signed (Month, Day, Year)

10/06/2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland		artment of Health and tificate of Death		giene 20   2	35897
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Joseph Marro Ber	to,	rcln'	2. Date of Dea Month	th Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 856/AF/as Dr		4b. City, Town, or Location of Dec	7.7		omery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 119–44–6378 59	Yrs.	If Under 1 Year If Under 24 Hi Months Days Hours Mi		year) Go, 1953 Ca	hplace (State' or Foreign untry) nada
	Maryland f show	tor	10a. State 10b. County 10c. City, T	own or Loc			~ ~ ~	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3e or 28e	il Directo	100. Street and Number 13130 Brandon Way Road	· CIICI	10f. Zip Code 20878		Og. Citizen of What Co	
920	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show affoal Exanal art must be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No 1977 − If Yes, Give Year or Dates: 1981	13. V	Vas Decedent of Hispanic Origin? if Yes, specify Cuban, Mexican, Pue		14. Race - Ame Black, Whit	rican Indian,
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 14	(Give I life. D	lent's Usual Occupation kind of work done during most of w DO NOT use retired) r/Partner	orking	16b. Kind of Business/ Biomedical Company	,
yland 2	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Pietro Bertoncini			ame (First, Middle, eine Arch	Maiden Sumame)	
	nd 2 sh lith and 27 is rr r treurr				g Address <i>(Street and Number or F</i> O Brandon Way Ro			
altimore,	permit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		1 ☐ Burial 2 🖺 Cremation 3 🖺 Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Metro	etery, crem polit	tan Crem. 20	i2 <sup>20</sup> ,	20c. Location - City or Alexandria	
Ball	permit Depart Import any in		21. Signature of Funeral Service Libensee  Cutton C. Duy (M01116)		Name and Address of Facility D  Bast Deer Park			MD 20877
4	Physician /Medical Examiner	<b>.</b>	23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ce of):	er the mode of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Batween Onset and Death
8760,	death certificate be executed eattending physicien and ad for use as the burial-transit	lical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen	·				
P.O. Box 6	death certiff e attending ed for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	ath 3□	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
	law requires that the death as been signed by the atte 2 should be detached for	þ	Part II. Other significant conditions contributing to death but not resultin	g in the un	derlying cause given in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	3.
ш	12 th 12	Completed				24a. Was a autops perforr 1 🗆 Yes	sy prior to d	topsy findings available completion of cause of 2 🗆 No
Ĭ.	ysicien s certifi director	To Be	25. Was case referred to medical examiner? 1 2 Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/	Outnatient	Othor	eath (Check only on	ence 6 ☑Other (Spe	nitul ACCIO
ion of	To the Hospitel or Attending Physicien: The I within 24 Hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 281	b. Time of Injury フュイ	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Divis	tel or Atte s after de el Directo ed in by th	Certification;	3.★ Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	farm, stre	eet, factory, office	CLI	treet and Number or Rin, State) 5 6 H	
	he Hospi n 24 hour he Funer pletely filli	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ige, death and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
ï	Mithi Com	Σ	29b. Signature and title of certifier  Mr. D. September 1995.	nma	29c. License number  DODY >		9d. Date signed (Month	n, Day, Year)
			30. Name and address of person who completed cause of death (Item 23.	DMC	Silver S	prima	my 20	904
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 3 2012  32 Registrar's Signature	par	Kal			,

				Pleas	se Type o							_		_	jible.	
			For State		State	of Maryla					and M	Mental H	ygien	е	0 (	0 0 5 0 0
		-	Registrar  1. Decedent's Nam	ne (First Middle	l ast)		CE	ertifica	ate of L	Jeatn		2. Date of D	Reg. N	lo. 2		2, 3589
	Physicia		Iris Bas									Octobe		8 <sup>y</sup> 20	Year	3. Time of Death 4:40 P M
	Medic Examir		4a. Facility Name (ii		give street and nu	m <i>ber)</i>		4b. C	ity, Town, o	r Location	of Death			c. County		
1	./	Н	Shady Gr						ckvil.					Monte	gome	ry
	Funeral Director		5. Social Security N 336-14-0		i. Sex 1 □ M 2 🕅 F	7. Age (In yrs	. last birthday)	Monti	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Day, Year)		g. Birt Co	thplace (State or Foreign untry)
	<b>&gt;</b>		Usual Residence		1 - M 2 22 1	87	Yrs.					April	2, 1	925	I11	inois
	ryland	ctor	10a. State	10b. County		I	City, Town or L									10d. Inside City Limits
	or 28e	Dire	Maryland 10e. Street and Nu	Montgo	mery	Roo	ckville		Zip Code				100.0	Citizen of \	Mhat Co	1 ☐ Yes 2 🛣 No
	with the	Funeral Director	303 Adc1	are Road	i				0850				_	ited		
	hours efter death with the Maryland natural", or items 23a or 28a-1 sho feet Examiner must be rediffed at	Fun	11. Marital Status		12. Was Dec	edent Ever in U	J.S. 13.	Was De	cedent of H	ispanic On	gin? (Spe	cify Yes or No	)-			ncan Indian,
36	efter al", or	d by	1 ☐ Never Man 3 🎇 Widowed	ried 2 Marrie	If Yes, Gi				2 <b>X</b> No			riicari, Gic.j		Specify:	k, White	e, etc. ucasian
Maryland 21215-0036	hour	Completed		15. Decedent's	Year or D s Education		16a. Dece	edent's U	sual Occup	ation	-		T 16h	Kind of B	Uai	
218	_ 55	E O	Elementary/Sec		grade completed College (*	-4 or 5+)	(Give	kind of t DO NOT	work done o use retired)	during mos						•
2	iled within 7 I Hygiene. other than	BeC	17. Father's Name	First Middle La		5+	Eleme	enta	ry Scl				_	olic		ools
aŭ	be file ental   'ked c	힏	Joseph K		si)							e (First, Middle 1ford	e, Maidei	i Surname	<del>)</del> )	
ary	hould end M Is mar		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mail	ling Addr	ess (Street a			l Route Numb	er, City o	or Town, S	itate, Zip	Code)
	ind 2 s lealth m 27 her tra		Audrey A		n – Daug						er Re	edDr.	Arli	ngto	n, V	A 22206
Baltimore,	permit. Page 1 and 2 should be filed within Department of Health end Mental Hygiene Important: If item 27 Is marked other thany Injury or other traumatic event, the once.		20a. Method of Dis 1 X Burial 2		☐ Removal from	20b. State	Place of Disp cemetery, cre	osition (Pematory o	lame of or other plac	e)	[	Date	20c.	Location -	City or	Town, State
Iţi	nit. Pa artmer ortant Injury		4 ☐ Donation 21. Signature of Fu	5 Other (Spe		Ag			Cemet							Virginia
Ba	Depar Impol any Ir		La	100)	Bull	mo	1530					fferso				•
		П	23a. Part 1. Enter t	the disease, or co	omplications that y one cause on ea	caused the de										Approximate
	Pnysician/		Immediate Cause disease or condition	(Final	Co	ardine	ulmor	1Ar	1 arr	rest						Interval Between Onset and Death
-	Medical Examiner		resulting in death)	4	Due to	(or as a combe	quence of):	/								
		Jer	Sequentially list co	onditions, omediata	D	Severe Coras a conse	ausana oft 1									
	executed an and irial-transit	al Examiner	cause. Enter Unde Cause (Disease or that initiated event	rlying	С.	advon	need	de	men	tin						
	e exec cian ar vurial-t	al E)	resulting in death)		Due to	(or as a conse	quence of):									
68760	cate b physic	edic			d										$\dashv$	
89	Hospital or Attending Physician: The law requires that the death certificate be executed 2.4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, ou						-5-0-			23d. Dat	te of deli	verv
Box	death he atte	sicis	in the past 12 to 1 Yes 2	K No		Birth 2  Fe mant at time of nown		Other		;y 			ľ	Mo		Day Year
P.O.	at the des d by the s detached	Phy	9 Unknown Part II. Other signif				esulting in the	underlvin	a cause aix	en in Part	1	an Did	4-5			the cause of death?
S, F	ires that signed to ld be det	Completed by			, , , , , , , , , , , , , , , , , , , ,		<b>-</b>	,	<b>J J</b>							obably 4 🗵 Unknown
Records,	w requires s been sig 2 should t	olete										24a. Was		24b. V	Vere aut	opsy findings available
Rec	The law cate has page 2	mo		-									opsy omed?	Ċ	leath?	ompletion of cause of
Ta_	siclan: The certificate rector, paq		25. Was case referre							ace of Deat	th (Check		2 /241	101 1	169	2 🗆 140
of Vital	Physion this craft dire	유	1 ☐ Yes 2 2 27. Manner of Deat		Hospital: 1 🗵 28a. Date	Inpatient 2	ER/Outpatie			4 🗆 Nu		me 5 🗆 Res				fy)
o L	tth. : After e funer	cate	1 Natural 2 Accident	5 Pending Investigat	(Mon	th, Day, Year)	injury	" M	28c. Injury work 1 □			28d. Describe	how inju	ry occurre	ed	
Division	r Attenc er death rector: /	Certificate:	3 Suicide 4 Homicide	6 Could no determine	t be 28e. Place	of Injury - At h		_							r or Run	al Route Number,
ă	oital or A urs after ral Direc	ia C	X	1	1							City or To		•		
		Medical	(Check 2		hysician: To the b miner: On the bas urse Practitione	sis of examinati	on and/or inves	stigation.	in my opinia	n, death oc	curred at	the time date	and place	and due	to the c	ause(s) and manner stated
	To the within 2 To the comple		29b. Signature and		urse Fractitioner	: To the best of	my knowledge		9c. License		te and plac	ce, and due to				Day, Year)
					ealy					7(32)	3		10/	18/12	2	
	305M		30. Name and addre	ess of person wh	o completed caus	se of death (Ite	m 23a) (Type,	Print)	Cont	ur D	m	Rent	callo	Mo	molor	ul 20850
	Stat	e_	31. Date filed (Monti	h, Day, Year)	37 R	egistrar's Sign	ature	Cont		UV I)	· · · · ·	, , ~ (10	VIIV	,	J	70000
	Registra	ır	0	C1 2 32	U12 /2	we ,	8. pa	exe								

Year

Maryland

DHMH 17 Rev 06-2011

 $\omega$ 

State Registrar Raymond White, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

- 1500 Forest Glen Road, Silver Spring,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Oden Bowie 4:15 2012 Ам October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baywoods of Annapolis Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 578-12-7348 Director 1 🖾 M 2 🗆 F 97 November 21,1914 Washington, DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location Director Maryland Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 4600 Fairview Vista Drive 20720 USA ed other than "natural", or items event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 X No b Maryland 21215-0036 filed within 72 hours after Yes 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Farmer should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Williams W. Booth Bowie injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau 4600 Fairview Vista Drive, Bowie, MD 20720 Ambler Slabe / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 10/23/2012 | Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Interval Between Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition Month Medical resulting in death) Due to (or as a consequence of) Examiner End Stage Dementia 4 Years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Pregnant at time of death Dav Year the a 9 Unknown Unknown signed by to Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, been sig should t Completed 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed Yes 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Assisted Other: 1 🗌 Yes 2 🛛 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred eral Director: After filled in by the funer 5 Pending 1 X Natural death. 1 Yes 2 No Investigation 2 L Accident Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral t

completely filled Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D29571 10/23/2012 1024

State Registrar

DHMH 17 Rev 06-2011

2200 Defense Highway, Suite 103, Crofton, MD 21114

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Bruce Berez, M.D.,

42012

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Tilghman Brice, IV October 3:15 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1820 Ritchie Highway Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 215-34-1742 Director 74 1**X**XM 2 □ F Feb. 18, 1938 Maryland Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura" any injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Ritchie Highway Funeral 21409 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black White etc þ 1 ☐ Yes **XX** No If Yes, Give 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard T. Brice, III Mary Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Brice/wife 1820 Ritchie Highway Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XX Cremation 3 Removal from State Baltimore Crematory 10/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Sig. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physiciani UM LANCEC disease or condition Medical resulting in death) Due to (or as sequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Que to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No 1 Yes Yes Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital Other: 뎯 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After 1 (Month, Day, Year) 5 Pending work? Natural 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ainer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month, Day, Year) 001217 10/18/12

State Registrar

DHMH 17 Rev 06-201

30 Name and ad

1000

31. Date filed (Month, Day, Year)

MYG

OCT 18 2012

Annipolis MO ZILLOI

210

VITC

pleted cause of death (Item 23a) Type, Print)

Midle.1

Amend #18 AACO Healt			<b>Please</b> 0-18-12	Type or Pr State of M										ible.	
КАН	-	For State Registrar		State of iv	iai yiai		eparime Certifica			and iv	neritai my		0.0	110	35902
		Registrar     Decedent's Name	e (First, Middle, Las	st)				ito or L	Journ		2. Date of D	Reg. N eath	0.		3. Time of Death
Physician Medica		Harve	1 But	+							Month	17	ay $\hat{\lambda}$	Year 2	1231 PM
Examine		4a. Facility Name (if	not institution, give	street and number)		- 1	4b. Ci	ty, Town, o	r Location	of Death		4	c. County	of Death	
		Universit	y of Mar	fland Med	11cal	ente	B		nore						
Funeral Director		5. Social Security No. 219-16-1 Usual Residence of	856 1	ex 7. Ag	ge (In yrs. I 87	ast birtho Yr	Month	der 1 Year Is Days	If Under Hours	Min.	8. Date of Bi (Month, D 10/29	ay, Year)	24	9. Birth Cou	nplace (State or Foreign ntry) VA
show at	ō	10a. State	10b. County		10c. Cit	y, Town c	r Location								10d. Inside City Limits
Maryk 18a-f	rect	MD	Anne Aru	ındel	Anna	apol:	is								1 ☐ Yes 2 🔀 No
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Num 710 Warre			·			Zip Code 1403				10g. C	Citizen of W	/hat Cou	intry?
death items		11. Marital Status		12. Was Decedent Armed Forces?		S.	13. Was Dec	edent of H	ispanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	-			can Indian,
36 after after kamir	d b	1 Never Marri	ed 2 X Married	1 🔼 Yes 2 🗆 If Yes, Give	No W	VII		2 X No					Specify:	k, White	
-00 lours	Completed	3 🗆 Widowed	15. Decedent's E	Year or Dates.		16a D	ecedent's U	sual Occur	ation			16h	Kind of Bu		ite
215	ᇤ	(Specification (Speci	cify only highest gr		5.4)	(0	Give kind of vie. DO NOT u	vork done d	during mos	st of worki	ng	100.	Killa of Ba	5111655/11	idustry
within giene the t, the		Elementary/0000	indary (0-12)	5+	54)	Ane	esthes	iolog	ist			Med	lical		
ind iffled tal Hy ed oth eveni	To Be	17. Father's Name (F									e (First, Middle		,		1 1
uld be uld be a Men	-	Harvey R				1					g O'Ne				beth
Ma 2 sho 2 sho th and traur traur		19a. Informant's Na Barbara				1					Route Numb			ate, Zip	Code)
and Heal		20a. Method of Disp	<del>_</del>	, use )	20b. F	Place of D	isposition (A	lame of			Date	T		City or 1	own, State
Page 1			$X$ Cremation 3 $\Box$ 5 $\Box$ Other (Specis	Removal from State	, 0	emetery,	crematory o Lc. Cre	r other plac			/2012		n Bui	•	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examone.	ı	21. Signature of Fur			1101						desty	_			
<b>a</b> a a a a a a		1950	J. C/m								apolis				
		23a. Part 1. Enter to shock, or hear	ne disease, or com t failure. List only o	plications that cause ne cause on each lin	d the deat e.	h. Do not	enter the m	ode of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
Physician/	ļ	Immediate Cause (I		. Subd	ral 1	ten	nato	ma					1		Onset and Death
Medical Examiner		resulting in death)		Due to (or as	a consequ	ience of):					0100	ul	W		
P. Farmer	ē	Sequentially list con	nditions,	b. Due to (or as	n overesti	NAME OF		- (	MAL	e d	alla	ME	a.	-	
rted ansit	Examiner	cause. Enter Under Cause (Disease or i	injury					(			ED BY MEDICAL	EXAMINE			
exect an an and rial-tra		that initiated events resulting in death) L		Due to (or as	a consequ	uence of):			*ERTIFICATI	ION APPRO					
50 te be nysiciá	glca			l d					05.					$\perp$	
387 rtifica ing pl	ğ	IF FEMALE:	- 1	00 1/	,										
Box 68760 death certificate be attending physical for use as the tenton of the control of the co	Physician/Medical	23b. Was decedent in the past 12 n	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	al death	3  Ectopi	c pregnanc	су			1	23d. Date Mor		/ery Day Year
ne deg	)Si(	1 Yes 2 9 Unknown	No	9 Unknown	at time or c	ıeam	5 Li Other	(specify) _							
P.O.		Part II. Other signifi	cant conditions o	ontributing to death I	out not res	ulting in t	he underlyin	g cause giv	ven in Part	1.	23e. Did	tobacco	use contri	bute to	the cause of death?
dS, uires uires uld be	Completed by	v									1 🗆	Yes 2	No	3 🗌 Pro	bably 4 🗆 Unknown
w req	plet										24a. Was		24b. W	Vere auto	ppsy findings available
Rec	E		-		_							ormed?	d	eath?	2 No
sian:		25. Was case referre examiner?							ace of Dea	ith (Check					
Division of Vital Records, all or Attending Physician: The law requires is after cleath.  In Director: After this certificate has been signed in by the funeral director, page 2 should be a signer.	의	1 Yes 2	I NO				atient 3 🗆	1	4 ∐ N		me 5 🗌 Res				y)
n o' ding l' h. funer	Certificate:	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 Pending	28a. Date of inju	y, Year)	28b. Tim inju	ıry	28c. Injun work	yat ⊲? Yes 2. <b>∑</b> X		28d. Describe	how inju	ry occurre	d	
Sio	Ĕl	2 Accident 3 Suicide	Investigation 6 Could not b		2012 urv - At ho		30PM street, fact		ies zys	_	28f Location	Street a	nd Numbe	r or Rura	d Route Number,
Saffer Saffer I Direction to		4 U Homicide	determined	building, et	c. (Specify	)				- 1	City or To	wn, State	e).	Α.	DO IS MD 21403
ospita hours unera	Medical			sician: To the best of	my knowl	edge, de				place, ar	nd due to the o	ause(s)	and manne	er as sta	ted.
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3	Certifying Nur	iner: On the basis of e se Practitioner: To th			dge, death o	courred at t	he time, da			the caus	e(s) and m	anner as	
North Con		29b. Signature and t	itle of certifier	P.	,		2	9c. License	e number			29d. Da	ate signed	(Month,	Day, Year)
Phys.		XX	re-	neer	-, 1	11)		V00	140	140		00	ric	) 2	1012
4/24		I	0 0	completed cause of c	leath (Item	0		o CL	001	D-I	timore	M	D 3	127	
State		31. Date filed (Month	n, Day, Year)	32. Fegistr	ar's Signat		reen	C 051	cel	Dal	DANO/6	1-1	VO		
Registrar		(	JCT 1820	112 June	m,	A. ,	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Raside Month 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 378 Blossom Tree Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 🗆 M 2 🖰 F Director 156-24-3065 77 11/17/1934 Dover, NJ or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 378 Blossom Tree Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. δ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve ည Irving Leon Rommel Naomi Mabel Counterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold R. Burnside/Spouse 378 Blossom Tree Drive Annapolis,MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2012 Crownsville,MD . Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 <u>©</u> . 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ DYSFUNETICK ener ASTRUCE disease or conditi-resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 2 No Day 5 Other (specify) Month Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 46 ٥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Gritfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). LUKKS 445 31. Date filed (Month, Day, Year) 32. Registrar's Signature **OCT 18** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 10 Physician/ 105AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death 910 Boacon WA EIJ GOT UNA Md · NNE Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Days Hours 231-42-8265 **Director** 1 ₹ M 2 □ F 1/22/1936 VIRGINIA 76 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 UNITED STATES 910 BEACON WAY 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 1057 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Year or Dates. 1957 Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 12 CPA PUBLIC ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANCIS BYRD LISA THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $910\ BEACON\ WAY$ , ANNAPOLIS, MD 21401ANDRINA BYRD/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 10/18/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses me and Address of Facility LA 'ENBEIN & NEWNA BESTGATE ROAD, M CRÉMATION ANNAPOLIS, it 1. Enter the dividase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliume. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death AUCER Physician/ disease or condition resulting in death) years Medical s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). attending physician and I for use as the burial-transi death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f b Hospital or Attending Physician: The law requires that the 24 hours after death.
24 hours after death.
Funeral Director: After this certificate has been signed by the letely filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 22 1 ☐ Yes 2 ☐ No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Investigation 6 Could not be 1 Tes 2 🗆 No Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatu and title of certific -18566 completed cause of death (Item 23a) (Type, Print) 969

DHMH 17 Rev 06-2011

Registrar

State

31. Date flied (Month, Day, Year)

OCT 1 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Actorner Ellen P. Baker 2012 8:52 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 232-72-2373 1 🗆 M 2 🔀 Director 66 Sept.3,1946 West Virginia Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shor must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12909 Beaverdale Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ò 1 Yes 2XXNo If Yes, Give þ 1 Never Married 2XX Married Page 1 and 2 should be filed within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2x No Specify. 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) P.G. Board of Ed. 12 Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Conner Freda Plum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Kenneth A. Baker/Spouse 12909 Beaverdale Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or once. 1 X Burial 2 Cremation 3 Removal from State MD Vet. Cem. Oct.22,2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funerer Se ce Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1. Phter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. ITONITI disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami DIVERTICULITIS burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last nding physician use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ίς Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OWER LOBE PNEUMONIA Division of Vital Records, 1 Yes 2. No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? INFECTION 24a. Was an page 2 has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ည 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 - Pending work 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 06-2011

only one

29b. Signature and title

30. Name and address of person

17

ho completed cause of death (Item 23a) (Type, Print)

12150

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MOD58275

ANNAPOLIS Rd, Suite 308, Glenn Dale, MD

Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylar	_	artment of F			giene Reg. No.	2012	35908
	Physicia	ın/	1. Decedent's Name (First, Middle,	BARKER				2. Date of De Month	ath Dav	Year	3. Time of Death 4 OFPM
-	Medic		4a. Facility Name (if not institution, c			Ab City Town or	Location of Death	•	12	2012 unty of Death	7 00
-	Examin	ier	Lange L Reen	and winta	L		w · U		Pr		Genges
	Funeral		howel Regn 5. Social Security Number	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h.		ace (State of Foreign
	Director		215-54-6469	1 □ M 2 🛣 F 84	Yrs.	Months Days	Hours Will.	Nov.4,	1927	Hunga	**
	nd now at	ايا	Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town or Lo	cation				<del></del>	Od. Inside City Limits
	arylar a-f sl	Director	MD Prince	George's		Hyatts	ville				1 🗆 Yes 2 ื No
	or 28 or 28 e noti		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Count	ry?
	with 1 s 23a ust b	Funeral	7038 Hunter Lar	ie		2	20782		US	SA	
	items items		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14.	Race - America Black, White, e	
36	after or I", or xamir	d by	1 ☐ Never Married 2 ☐ Marrie 3 XXVidowed 4 ☐ Divorced	d 1 ☐ Yes 2 <b>X X</b> No If Yes, Give	I .	1 ☐ Yes 2xxx No				ecify: White	
21215-0036	atura cal E	Completed	15. Decedent	Year or Dates.	16a. Dece	dent's Usual Occupa	ation			of Business/Ind	
215	n 72 ł an "n Medi	ldm	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done a O NOT use retired)	uring most of work	king			,
21	withii giene <b>ser th</b> t, <b>the</b>		Elementary/ occordary (o 12)	College (1-4 or 5+)	Home	maker			Own H	lome	
pu	tal Hy od oth	To Be	17. Father's Name (First, Middle, La	\$t)			18. Mother's Nan		Maiden Surr	name)	
yla	uld be 1 Men narke natic	-	Miklos Nagy		1		01ga I				
Maryland	2 sho th and 27 is r traur		James R. Barker,			ng Address (Street a				vn, State, Zip G	ode)
ā,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of	1	Date		ion - City or To	vn, State
Baltimore,	ent of ent of nt: If i		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	- Hellioval Ilolli State	cemetery, crei D Vet.	matory or other plac Cem.		17,2012	Crow	nsville	2
altii	mit. F partm porta  / injui		21. Signature of Funeral Service Lie			2. Name and Addres					
m	l m l		Shit-	3		512 NW C1					
			23a. Part 1. Enter the disease, or shock, or heart failure. List on	omplications that caused the dealy one cause on each line.	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	a. Sepsis Due to (or as a consec							Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):						
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):						
09	nte be hysici the bu	Physician/Medical		d							
68760	eath certificate attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy						
Box (	ath ce attenc for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2 Fel	tal death 3	Ectopic pregnanc     Other (specify)	у		230	<ul> <li>Date of delive</li> <li>Month</li> </ul>	ry Day Year
W	he dea y the a Iched	nysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown							
P.O.	requires that the been signed by t should be detack		Part II. Other significant condition	s contributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to the	e cause of death?
ds,	quires an sign auld b	Completed by	myocardial	Infanction.	Am	o-mul	hwer	1 🗆	Yes 2	√o 3 □ Prob	ably 4 🗌 Unknown
Ö	has bee	plet	function,	Acute rev	al f	alle		24a. Was auto		prior to con	sy findings available npletion of cause of
Records,	The la	Som						perfo	2 No	death?	2 🗆 No
Vital	nysician: The nis certificate I director, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Pl	ace of Death (Chec	ck only one)			
of Vi	Physi this o	2	1 Yes 2 No  27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatie	nt 3 LL DOA	4 ☐ Nursing H	ome 5 Resi			
n o	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investiga	(Month, Day, Year)	injury	work		26d, Describe i	low injury oc	curred	
Sio	Atten rr dear ector: by the	Certificate:	3 Suicide 6 Could not determine	ot be 28e. Place of Injury - At h		reet, factory, office				umber or Rural	Route Number,
Division	tal or rs afte al Dir			building, etc. (Special				City or Tov			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination	on and/or inves	stigation, in my opinio	on, death occurred a	at the time, date a	and place, and	d due to the cau	se(s) and manner stated.
	thin 2 the I	Me		Nurse Practitioner: To the best of			he time, date and p		the cause(s) a		tated.
	5 <u>≥ 5</u> 8		V.	. •					Lou. Date S	LO 14	12
			30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type.	Print) 7200	Van Duse	n Rd.	Laura	el, MD	20707
(0)	410		Adedeji	Karuwi	h	ainel	Regio	nal b	soul	al	10 1
	Sta Registr		31. Date filed (Month, Day, Year)	2012 32. Registrar's Sign	ature	harles	0				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARRIERE D'all Medical 4a. Facility Name of not institution, give street and number Examiner 4b. City. Town, or Location of Death 4c. County of Death Randallstown Baltimore County Northwest Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 111-14-1885 1 ☐ M 2XXF 89 March 26,1923 NY Usual Residence of Decedent event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Laurel 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11510 Basswood Court 20708 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No within 72 hours efter Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3x Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hospitals Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mentel
Important: If item 27 is mo-၉ Alexander Eftimoff Calini Traicheva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris McKay/Daughter P.O. Box 2565 Laurel, MD 20709 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State MD Vet. Cem. Oct.22,2012 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD 20715 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate mock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami After this certificate has been signed by the attending physician and s funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' 25. Was case referred to medical or Attending Physicien: 26. Place of Death (Check only one) examiner? 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death To the Funerel Director: A completely filled in by the f 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Littifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Prigt) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 201<sup>Yea</sup> 13 Thelma R. Butler 4:30 рΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 12319 Madeley Lane Bowie If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, Months 246-42-3781 **Director** 1 M 2XXF 82 Yrs Nov. 29,1929 North Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 xXYes 2 □ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 r than "natural", or items 23a of the Medical Examiner must be Funeral 12319 Madeley Lane USA 20715 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Principal Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) Lula Waddell Isaiah Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence W. Butler, Sr./Spouse 12319 Madeley Lane, Bowie, MD 20715 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State Oct.20,2012 Laurel, MD MD Nat'1.Mem.Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD 20715 23a Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or, attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 r use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 24 No 2 No 1 🗌 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a

To the Funeral C

completely filled the Hospital

DHMH 17 Rev 06-2011

Registrar

Medical

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Drive Suite

29d. Date signed (Month, Day, Year)

3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 6:25 A M Linde David Bakke 10 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salsbury Hospice At the Lake W 1 comico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Davs Hours Min. (Month, Day, Year) **Director** 222-40-0746 1 XM 2 □ F 58 Yrs Apr. 25,1954 Delaware Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at Director notified 28a-f 1 X Yes 2 No MD Worcester Berlin 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 103 Purnell Avenue 21811 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working ath and Mental Hygiene.
27 is marked other than "r life. DO NOT use retired) Entertainment Elementary/Secondary (0-12) College (1-4 or 5+) Musci Entertanment Musician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Earl Finn Bakke Marjorie Helen Howarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marlena Carol Bakke / Wife 103 Purnell Ave., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Parsell Funeral Homes 10/18/2012 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lewes, Delaware Crematorium permit. Signature Funeral Service Line nsee Name and Address of Facility Parsell Funeral Homes & Crematorium 16961 Kings Highway, Lewes, DE 19958 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Neoplasm Months Months Immediate Cause (Final malignant Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in redictor cause. Enter Underlying Examine Que to (or se a nonecquence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 🖳 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Funavoli-Sheehan, D.D. H68413 30. Name and address of person who completed gause of death (Item 23a) (Type, Print). Box 1733 Solisbury 21802

Registrar

1 V Natural

29a. Certifier

(Check

2 Accident
3 Suicide
4 Homicide

5 Pending

Investigation 6 Could not be

determined

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Year

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Hours Min 579-24-9155 Director 1 ☑ M 2 ☐ F 86 Yrs WASHINGTON, D.C 02-23-1926 Usual Residence of Decedent permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director DELAWARE SUSSEX OCEAN VIEW 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 632 BRIDGE LANE 19970 UNITED STATES 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1944-1946
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ASBESTOS WORKER UNION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ THOMAS B. BREWER EMILY BARRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA A. BREWER / DAUGHTER 1256 WASHINGTON DRIVE, ANNAPOLIS, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Pege 1 1 🖾 Burial 2 🗌 Cremation 3 🗋 Removal from State GATE OF HEAVEN CEMETERY 10-20-12 DAGSBORO, DELAWARE 4 Donation 5 Other (Specify) and Arthren Arcilla ERVICES, LTD. MUDDY NECK RD., OCEAN VIEW, DE 19970 e disease, or complications that caused failure. List only one cause on each line. for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Adenocacinama Physician patobiliden disease or condition ONE MONTH Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate rause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physiclan: The law requires that the death certificete be executed that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed in funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physiclan: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA မ 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Compared Accident
Solicide
Compared Accident
Compared Acci injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a D29193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Braverton St # 201; Edgewater Mar. lian 3169 15+1 31. Date filed (Month, Day, Year) Registrar's Signature State OCI Registrar

DHMH 17 Rev 06-2011

		Please	State of Maryla				•		gibie.		
		For State	State of Maryla		tificate of De				0010	250	
		Registrar  1. Decedent's Name (First, Middle, Last	t)		illicate of be		2. Date of Death	eg. No.	014	3. Time of Death	_
Physicia Medic		Robert Ca	rleton Baker				October	<sup>Day</sup>	2012	09:35 AM	ţ
Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or L	ocation of Death			nty of Death		
a5		Union Hospital of			Elkton			Ce	cil		
Funeral Director		5. Social Security Number 6. Se 155-22-4806	X M 2 □ F 7. Age (In yrs	s. last birthday)  Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 24)	Year)	9. Birthpl Count	lace (State or Foreign ry) <b>Jersey</b>	7
-		Usual Residence of Decedent	0	0			May 24,	1932	I New	Jersey	
/land f sho	tor	10a. State 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits	
Many 28a- notifie	)irec	Maryland Cecil		North						1 Yes 2XX	)
ith the	Funeral Director	10e. Street and Number 91 Ridge Run Roa	d		10f. Zip Code 2190	1	1		of What Count d Stat		
ems :	ine	11. Marital Status	12. Was Decedent Ever in	U.S. 13. <sup>1</sup>	Was Decedent of Hisp	panic Origin? (Sp	ecify Yes or No-	_	ace - America		
fter de , or it	þ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No No		f Yes, specify Cuban,		Rican, etc.)		ack, White, e	tc. ite	
urs al tural" al Exa	Completed	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates. 195	1-56		Specify:		Speci			
72 hc n "na Aedic	nple	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occupati kind of work done dur O NOT use retired)	ion ring most of work	ing	16b. Kind of	Business Ind	ustry	
vithin jene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+) <b>4</b>	1	or Vice Pr	esident		Insur	ance		
filed valued val	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M				
ld be Ments arkec	မ	John Baker				Avis Mu	riel Aum	ack			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty) Gary T. Baker / S			ng Address (Street and ast Cherok					ode) 19713	
1 and 2 of Healt item 2		20a. Method of Disposition		o. Place of Dispo			-		n - City or Tov		_
Page 1 ment of ant: If ii ury or c		1 ☐ Burial 2 🎇 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	matory or other place)  Cremator		Jer 77,		, Dela		
permit. P Departm Importar any injur once.		21. Signature of Funeral Service License		-	2. Name and Address	- i					
permi Depar Impo any ir once.		(May)		12	27 South M	lain Stre	eet, Nort	h Eas	t, Mar	y1and2190	1
_		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		eath. Do not ente	er the mode of dying,	such as cardiac	or respiratory arres	st,		Approximate Interval Between	
Physician/		Immediate Cause (Final disease or condition	a		Myelod	ysplas	stic Syr	rdro	ne	Onset and Death	
Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	River	01.					
	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conse	equence of):	Ineu	mone					
ansit ted	Examiner	cause. Enter Underlying Cause (Disease or linjury									
be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
cate be ex physician the buria	dical		d					_			_
eath certificate battending physical for use as the batter to the batter	/We	IF FEMALE:	23c. If yes, outcome of pred	nancv				00.1	2-1		
ath cattering for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ctopic pregnancy Other (specify)				Date of delive <i>Non</i> th	ry Day Ye <b>a</b> r	
the de by the ached	Physician/Medi	9 Unknown	9 □ U <i>n</i> known								_
s that gned b	by	Part II. Other significant conditions co	ontributing to death but <i>n</i> ot i	resulting in the u	inderlying cause giver	n in Part I.				e cause of death?	
equire sen si ould b	ted						1 ∐ Ye			ably 4 💢 Unknow	
law re has b	Completed						24a. Was an	/	<ul> <li>Were autop prior to con death?</li> </ul>	sy findings available npletion of cause of	
n: The ficate r, pag		25. Was case referred to medical			00 PI	10 11 01	perform 1 Yes 2	No	1 Yes	2 No	
sicial s certii lirecto	To Be	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpaties	Other	e of Death (Chec	ome 5 Reside	200 6 🗆 0	thor (Specify)		_
ig Phy er this neral c		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of			28d. Describe hov				_
eath. or: Af	ifica	1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		,,	M 1 Ye	es 2 🗆 No					
or Att after d Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Str. City or Town,		ber or Rural i	Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1. Certifying Phys	ician: To the best of my kno	owledge, death	occured at the time. d	late and place, ar	nd due to the caus	e(s) and mai	ner as stated	d.	_
n 24 h	Medical	(Check 2 Medical Examin	ner: On the basis of examinate Pragitioner: To the best of	tion and/or inves	tigation, in my opinion,	death occurred a	t the time, date and	place, and	due to the cau	se(s) and manner stat	ed.
To the within To the COTTE	-	29b. Signature and title of certifier	Mha :	0	29c. License n	number	29	ld. Date sigr	ned (Month, P	ay, Year)	
101		<b>•</b>	05/	MO	D	00621	70	10	23	12	
IVA		30. Name and address of person who co		em 23a) (Type, F	Print) SHAHA VY SUITE	VAWAZ	KHAN N	MI	1 1711	110719	<i>(</i>
Stat	9	2533 AUGUST I	NE HERMA 32. Registra's Sig	nature	VY I SUITE	H, e	KIESMPE	1114	-114	MUDIN	<u>. د</u>
Stat Registra		061 24	+ 2012 Densu	a B.	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Beverly A. Baker October 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22 Farragut Court E1kton Ceci1 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Aug. 22,1938 Days Hours Director 157-28-2385 1 🗆 M 2 🛛 F 74 New Brunswick ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland at Hygiene. 1 other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 22 Farragut Court 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Completed 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) State of New Jersey Court Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any linjuy or other traumatic even 900.8. ပ္ Charles M. Weber Ruth Amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>George E. Baker, Jr./ Spouse</u> Farragut Court. Elkton. Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State October 27 Neshanic, New Jersey Neshanic Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Le 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only or Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burlal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 🔲 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 3 Residence 6 Other (Specify) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 11, 201<sup>Yea</sup> CALVIN FRANKLIN BAYNARD 11:59 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CAROLINE DENTON 604 CAROLINE APARTMENTS 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) **Funeral** 8 Date of Birth Days Hours Min (Month, Day, Year) 214-68-6734 Director 1 M 2 □ F 57 2/13/1955 MARYLAND Usual Residence of Decedent iral", or items 23a or 28a-f sho Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director MD CAROLINE DENTON 1 X Yes 2 No 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 604 CAROLINE APARTMENTS 21629 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ð 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 MAINTENANCE LANDSCAPING 6 i. Page 1 and 2 should be filed with therit of Health and Mental Hygier tant: If item 27 is marked other 1 jury or other traumatic event, the standard of the standard or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSALEE FAIRBANK BENJAMIN FRANKLIN BAYNARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21629 1133 MARKET STREET, DENTON, MD SHIRLEY M. MORRIS, SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it eny injury or o 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify CHESAPEAKE CREMATION | 10/22/2012 | STEVENSVILLE, MD 21. Sign for f Funda Removed Address of Facility ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, POSTECT, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ 5month disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 perform 1 Yes filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at After 1 5 Pending work? 1 ☐ Yes 2 ☐ No Natural s after death. Accident Investigation 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teal Drive Suite 302, Q. William Gai, M.D. 8221 Teal Drive Suite 302, MD Easton Q. William 31. Date filed (M 32 Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0959AM Day 10 2012 Brohawn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death ambrid wordester Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 219-14-3204 1 M 2 F 88 August 27,1924 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Mexical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5423 White Hall Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Mexical Examinonce. Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: white Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) audit manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard A. Bradshaw Beatrice Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard V. Brohawn Jr. 3506 Aeberle Rd., East New Market, MD son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🖫 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem. 10/23/12 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Se 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedia cause. Enter Underlying Examine Dire to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) signed by the at I be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Aftert Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yea 10-2-3 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar

Pleare Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend 23a, Part I Registrarpor, 10/19/12, LDB

1. Decedent's Name (First, Middle, Last) Amend 23a, Part I per phys. Certificate of Death 2. Date of Death Month october Physician/ Emerson Thomas Bramble 2012 0928 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town 4c. County of Death Examiner Dorchest General Cambr If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last b (Month, Day, 1 😿 M 2 🗆 F 218-14-4336 85 T927 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Dorchester Cambridge 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 407 Glenburn Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Narried þ Maryland 21215-0036 If Yes, Give Year or Dates. white 1 ☐ Yes 2 🕱 No Specify WWII Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) claims adjuster insurance Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Thomas Bramble Oneita Dayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brambl Bettie H. Bramble wife 407 Glenburn Avenue, Cambridge, MD 21613 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 10/18/12 4 Donation 5 Other (Specify) Delmar, DE Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner horame Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events - Acute Renal Disease the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been siç , page 2 should b Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe within 24 hours after deam.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 1 Yes 2 No Accident Investigation ☐ Suicide
☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2 nmed who completed cause of death (Item 23a) (Type, Print) 300 Annu 31. Date filed (Month, Day, Year) Registrar's Signatur State OCT 1 Registrar

massan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 359 | 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 0023 AM Andreas Arnold Brooks Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death REGIONAL MEDICAL Center 3AL156414 NICOMICO PENINSULA 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 214-07-7272 97 1 😾 M 2 🗆 F May 8, 1915 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28e-f Dorchester Cambridge 1 X Yes 2 No 10e Street and Number 10g. Citizen of What Country? 5 10f. Zip Code Funeral filed within 72 hours after death with 1 items 23e 21613 USA 507 Burton Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give WWII Year or Dates. 6 þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: "naturel", 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health end Mental Hygiene. tent: If Item 27 is marked other then iury or other treumetic event, the My Elementary/Secondary (0-12) College (1-4 or 5+) master carpenter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Freida Schulze Charles Wesley Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21631 6316 Snug Harbor Rd, East New Market, MD Doris Era daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 A Burial 2 Cremation 3 Removal from State Dld Trinity Churchyard 10/22/12 Church Creek, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Rome P.A. 21. Signature of Funeral Service Licenses Well Peronica M. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Infall m Immediate Cause (Final myscardial Pnysician/ cute disease or condition Medical resulting in death) Due to (or as a consequence of) Atheroscheum. Examiner ronder 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burs efter death. eret this certificate has been signed by the attending physician end filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Exam Hospital or Attending Physicien: The lew requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 00000 Aomic stends: 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 2 × No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical 1 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d, Date signed (Month, Day, Year) D25036 10919112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHURIE Dr. SALISIBUM. MA 614 HEM R. . Registrar's Signature State Registrar

12-07770 Albert A. Castro

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

roude i	. ypo or a anne ma one	ton machine		
	State of Maryland /	Department of L	lealth and Me	antal Hygiene

J P			-		
State of Man	vland / Departmen	t of Health	and	Mental	Hygien

0 0		0 =	0	
20	12	35	9	

		- For State tegistrar		Certifi	cate of L	Death		Re	eg. No.	012 3331
Physicia	n/	Decedent's Name (First, Middle)						Date of Deal     Month	th Day Yea	3. Time of Death 1358 hrs
Medical Examin		Albert Atanac			Lab	. City, Town, or Lo	nantian of Doot	October 1	3, 2012 4c. County o	
	•	4a. Facility Name (if not institution Civista Medical Cente	_	,		La Plata	ocation of Deat	11	Charles	Death
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last b	oirthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Bir	th (MM/DD/YYYY)	9. Birthplace (State or
Director		585-38-9459	1XM 2_F		62 Yrs.	Months Days	Hours Mir	03/01/	1950	Foreign New Country) Mexico
		Usual Residence of Decedent			<u> </u>			03/01/	1750	
A any	Γ	10a. State 10b. County		10c. City, Tow	vn or Location	1				10d. Inside City Limits
Maryland 28a-f show d at once.	١	MD Chai	cles	La F	lata					1 Yes 2 No
Mary r 28a-	Director	I0e. Street and Number				10f. Zip Code		1'	0g. Citizen of Wh	at Country?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.		11930 Knollcre			140.144	20646			USA	American Indian Plant
ath wi	<b>a</b> l	1. Marital Status  1 Never Married 2 X M	12. Was Decedent	?		Decedent of Hispa , specify Cuban, I			- 14. Race White	- American Indian, Black, e, etc.
ter de	Ē	_	1 X Yes 2	No	1 X Y	es 2 No	specify:		Specify:	Hispanic
21215-0036 uld be filed within 72 hours after de Mental Hygiene. marked other than "natural", or cevent, the Medical Examiner m	হ⊢	15. Decedent's Education (Spe	or Dates:	mpleted) 16a	a. Decedent's	Usual Occupatio			16b. Kind of Bus	
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mos	t of working life. [	OONOT use re	tired)		
within ene.	틹		1		Progra	m Manage				l Government
filed Hyg		<ol> <li>Father's Name (First, Middle,</li> </ol>	,			16			/laiden Surname)	
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than atte event, the Medica	e Be	Atanacio Cast  19a. Informant's Name/Relations	iro hip (Type, Print )	11	l9b. Mailing A	ddress (Street	Lola G		ber. City or Town	n, State, Zip Code)
☐ sh and sh ☐	-	Patricia Cast		- 1					ta, MD 2	
ore, ML es 1 and 2 s of Health at fritem 27		20a. Method of Disposition		20b. Place	e of Disposition	on (Name of ceme	etery,	Date	20c. Location -	City or Town, State
MOre Pages 1 nent of H	- 1	1 X Burial 2 Cremation 4 Donation 5 Other Sp		ale	-		-Cem11/	14/2012	Arlingto	on VA
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	12	21. Signature of Funeral Service		P-12	22. Nar	ne and Address o				F.H., P.A.
E B S B	1	Virt W		101458	301	95 Three	Notch	Rd., Ch	arlotte	Hall, MD 20622
Physician	2	23a. Part I. Enter the disease, or failure. List only one cause		the death. Do	not enter the	mode of dying, se	uch as cardiac	or respiratory arre	est, shock, or hea	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)								Death
	- 1		Due to (or as a cons	equence of):						
	إَع	Sequentially list conditions, f any, leading to immediate	Due to (or as a cons	equence of):						
	티	cause. Enter Underlying Cause Disease or injury that initiated	c. Due to (or as a cons	equence of):						
ansit		events resulting in death) Last	d.	equeries or).						
760, frate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED							
760, icate be physic the bur	ğ	F FEMALE:	23c. If yes, outcome	me of pregnanc	у				23d, Date of	delivery
Sox 687 leath certifi e attending for use as t	ia k	3b. Was decedent pregnant in the past 12 months?	I - Ento Birtin	t time of death	_ =		_Ectopic pregn	ancy	Month	Day Year
Box 68 e death certif the attending ed for use as	hysician	1 Yes 2 No 9 Uni	known 9 Unknown		⊃ Othe	r (Specify)			1	11
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it.	<u>-   1</u>	Part II. Other significant condit	ions contributing to deat	h but not result	ing in the und	derlying cause giv	en in Part I.			bute to the cause of death?
ires that the signed by	ă b					<u>-</u>		1 Yes	2 V No 3	Probably 4 Unknown
rds v requi								24a. Was autop		Vere autopsy findings available rior to completion of cause of
Records,  The law requir ficate has been s	Completed							perfor 1 ✓ Yes		eath?  Yes 2 No
	ည်း ကို	25. Was case referred to medica examiner?					f Death (Check	only one)	1	
of Vital ng Physician ther this cert neral directo	၉၂	1 ✓ Yes 2 No		ent 2 🗸 ER/				ng Home 5		Other:
ding Ph.		27. Manner of Death  1 Natural 5 Pend	28a. Date of Inju (Month, Day, ) FOUND:	rear) 28t	o. Time of Inju DUND:	·   _ · ·	at Work? es 2 ✔ No	Fall from he	now injury occurre ight	ed
Sior Attend death ector: by the	<u></u>	= o Felk	stigation Oct 13, 2012	12	58 hrs	factory, office bui		28f Location /	Street and Numbe	er or Rural Route Number, City
Division tal or Attendin rs after death. al Director: A led in by the fu	린	dete	d not be (Specify) Wo		, Iairii, Sileei,	ractory, office but	iding, etc.	or Town, S		
Tospit Tospit Topour Topour Superi	O	4 Homicide 29a. Certifier 1 Certifying Pl	hysician: To the best of m		death occurre	d at the time, date	e and place, an	1		
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		(Check only property) Medical Exa	miner:On the basis of exa and manner stated.	imination and/o	r investigation	n, in my opinion, o	death occurred	at the time, date	and place, and du	ue to the cause(s)
F 3 F 8	\$   ≥	29b. Signature and title of certifie				29c. License	number		29d. Date signe	ed (Month, Day, Year)
		Cande,	Hallav			O.C.M	.E.		October 14	, 2012
	3	30. Name and address of person					. 5	ND 04555		
0+1 RME			Assistant Medical E		900 W. Ba	Iltimore Stree	t, Baltimore	e, MD 21223		
Sta Registr		31. Date filed (Month, Day, Year)	2012 Registra	ar's Signature	park	1				
DHMH 17 Rev 1/20		<u> </u>	Cycles	Ö	RIGINAL	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:23 Collins Phoebe Faye October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Callaway Hospice House of St. Mary's St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min. Hours Director 217-36-7542 1 M 2 X F 73 Yrs 08/10/1939 Washington, DC Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No La Plata Maryland Charles 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? must be r Funeral 20646 USA 137 West Quail Lane items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Was Deceue... Armed Forces? Yes 2 X No Examiner Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. White "natural" Completed 3 X Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Public Schools 12 Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Thelma Hartley traumatic Frank Corkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 Robin J. Owens/ Daughter 41644 Queens Landing Road Mechanicsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Mattingley-Gardiner 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, PA. Crematory 10/23/2012 Leonardtown, MD 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A
41590 Fenwick Street Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ stru disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death signed by the a ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has bage ; certificate 2 No Yes 2 No 1 Yes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes ္ပ 1 Inpatient 2 ER/Outpatient 3 DOA HUSOLCE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred louse 1 Natural injury 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation etely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 29c. License number

State Registrar 30. Name and address of person with

Μ.

Jennifer

31. Date filed (Mo

Schmidt

20900 Mechants Lane, #205, Leonardtown, MD

completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

557

20650

	Al	MEN	D #25, 27, 28A-F	se Type or Pri PER ME G9 State of M	i <b>nt in l</b> 33 11 arylan	Black In	delible In	<b>k. Ensure A</b> Health and M	All Copie	s Ar	e Legible	
			For State Registrar	Otato of W	iai y iai i		tificate of L		inoma. Try	Reg. N		2 35919
	Physicia		1. Decedent's Name (First, Middle, I William Arthur	,					2. Date of De	eath	Pay 2 2 Year	3. Time of Death
	Medi Examir		4a. Facility Name (if not institution, g		ento	24	4b. City, Town, o	r Location of Death	1	4	c. County of Deat	rlos
5	Funeral		,		je (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	rth ay, Year)	9. Bir Co	thplace (State or Foreign untry)
5	Director		579-40-0027 Usual Residence of Decedent	1 X M 2 □ F	8	3 Yrs.			03/24			oort, MD
M0904	e Maryland r 28a-f show notified at	ctor	10a. State 10b. County			, Town or Loc						10d. Inside City Limits 1 ☐ Yes 2 💆 No
0	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	MD Char	Les	Ch	arlott	e Hall 10f. Zip Code			10g. (	Citizen of What Co	
5	h with ns 23a nust b	nera	11905 Budds Cre	· ·			2062				USA	
CL M 15-0036	2 hours after death with th "natural", or items 23a o edical Examiner must be	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 Yes If Yes, Give Year or Dates.	Ever in U.S No		las Decedent of H Yes, specify Cuba	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, White Specify: White	e, etc.
200	72 hours n "natur ledical	Completed	15. Decedent's (Specify only highest	s Education		16a. Deced	ent's Usual Occup	oation during most of work	ing	16b.	Kind of Business	•
			Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DC	NOT use retired) rmer				Self-Emp Farmin	•
26	filed w tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Las	•				18, Mother's Nam	e (First, Middle	, Maide		
Máryland	should be filed with and Mental Hygien is marked other ti raumatic event, the	٦	William Raymono 19a. Informant's Name/Relationship		•	10h Mailin	n Address (Street	-	nna Sto			Cadal
Σ,	2 ≠ 2 +		Barbara E. Simp		hter	1	-	and Number or Rura imore Rd.,		_		
Sa	ge 1 and it of Hea it fitem or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		20b. P	lace of Dispos emetery, crem	ition (Name of atory or other plac	ce)	Date	20c.	Location - City or	Town, State
Baltimor	permit. Page 1 Department of Important: If i any injury or once,		4 ☐ Donation 5 ☐ Other (Special Sign of Fu ral Service Lice		Chu	St. Ma rch Ce	netery  Name and Addre	port 10/2	7/2012	CI	narlotte	Hall, MD
B	Per		Amer CE	1 / 1/13.	10081	7 30	195 Thre	ee Notch E	Rd., Ch	arlo	otte Hal	1, MD 20622
5			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final			n. Do not ente	the mode of dyin	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of):						
	Examiner	ē	Saquartially list conditions,	fre	imit	2009	x		-//	it	EXAMMER	
- 3	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence on:	15	F	A PROVED BY	MEDICAL		
	e executed cian and ourial-transit		resulting in death) Last	Due to (or as		11	, , ,	CERTIFICATIO	(Pa			
. 2	icate b physical as the b	ledic		d	um	- ( )	M /					
Many . Box 68760	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	Ideath 3 🗌	Ectopic pregnand Other (specify)	су			23d. Date of de Month	livery Day Year
F.O.	s that t gned b be deta	by P	Part II. Other significant conditions	1	(	1		ven in Part I.	1/	•		the cause of death?
ords	require been si should	leted	Portul	1 yenetro	P	4/1/31	1.	15456	- /			robably 4 Unknown topsy findings available
w ∈ A Records,	S 55 S	Comp	1 as Kinson	a is tay	/	045	and a	Jusaha	auto	psy ormed?	prior to death?	completion of cause of
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?	Hospital:	ient 2 🗆	ER/Outpatien	Oth	er:		idence	6 Other (Spec	ifu)
್ರೌರ	ing Phy (fter thi uneral		27. Manner of D ath  1 ✓ Natural 5 ☐ Pending	28a. Date of inju (Month, Da	iry	28b. Time of injury	28c. Injur work	y at </td <td>28d. Describe</td> <td>how inju</td> <td>ury occurred</td> <td></td>	28d. Describe	how inju	ury occurred	
Division	Attend r death cctor: A	Certificate:	2 X Accident Investiga 3 Suicide 6 Could no 4 Homicide determine	ot be 28e. Place of Inj	ury - At ho	UNK me, farm, stre			28f. Location (	Street a	IPPED &	ral Route Number,
Divi	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	al Ce	1	DECK					ROAD, C	HAR	LOTTE HA	
	e Hosp 124 hol e Fune iletely fi	Medical	(Check 2 Medical Exa	thysician: To the best of aminer: On the basis of a line of Fractitisms.	examination	and/or investi	gation, in my opinio	on, death occurred at	t the time, date	and plac	ce, and due to the	cause(s) and manner stated.
	To the within To the comp	_	29b. Signature and title of certifier	1			29c. Licens		/	29d. D	ate signed (Montl	
			30. Name and address of person wh	no completed cause of o	leath (Item	23a) (Tvna P	int)	133421	0	/ [	127/1	<u>d</u>
(T	Rme		Larry Jenkins	Jr MO	PO F	$2 \times 2$	265 6	a Plata	a, MC	2	0646	
1 2	Sta Registr		31. Date file I (Month, Day, Year)  OCT 2 5	2012 32. Fegistr	ar's Signati	d.	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Mary		artment of H			2111	2 35920
Physic		1. Decedent's Name (First, Middle, Last) Frederick Joseph CO(				2. Date of Death	g. NO.	3. Time of Death
Med Exami		4a. Facility Name (if not institution, give street and number) 742 Antietam Drive		4b. City, Town, or Hagerst		occoper	4c. County of De Washing	eath
Funera Director		5. Social Security Number 216-68-5189 6. Sex 7. Age (In Usual Residence of Decedent	yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 17	Year) (	Birthplace (State or Foreign Country) aryland
Maryland 28a-f shov otified at	Director	les a al co a c	c. City, Town or Local Hagerstow		,			10d. Inside City Limits 1 ☐ Yes 2X No
th with the ns 23a or must be n	Funeral D	10e. Street and Number 742 Antietam Drive		10f. Zip Code 21742		11	U.S.A.	Country?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 🛣 No	, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. white
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam note.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k	ent's Usual Occupa iind of work done du NOT use retired) cker		ing	6b. Kind of Busines	
ind 2	To Be	17. Father's Name (First, Middle, Last)	320			e (First, Middle, Ma	aiden Surname)	
aryla	-	James Coop  19a. Informant's Name/Relationship (Type, Print)	19h Mailin	g Address (Street ar			sephine F	
Mg William Shall was the all the art and the art are art and the art are also		Dorothy Engle - mother	742 A	Intietam I				
Limore Page 1 a tment of P tant: If ite jury or ot			20b. Place of Dispos cemetery, crem Hagerstow				oc. Location - City	or Town, State
Ball permit Depart Import any in		21. Signature of Euneral Service Licensee	22.	Name and Address	of Facility M	innich F	uneral Ho	
Phylicin Medical Examiner	1	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a formula in the condition of the co	death. Do not enter					Approximate Interval Between Onset and Death
bU te be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a conditions, if any, leading to impury that initiated events resulting in death) Last  c. Due to (or as a conditions, if any, leading the property of the cause of the ca						
. Box 687  Be death certificate the attending potential contractions.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time pregnant at time g ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
dS, P.O quires that the signed by ould be deta	ğ	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
DIVISION OT VITAI HECONGS, tal or Attending Physician: The law requires s's after death.  I Director. After this certificate has been signed in by the funeral director, page 2 should be a control or the funeral director.	Completed					24a. Was an autopsy perform 1  Yes 2	prior to ed? death?	autopsy findings available completion of cause of es 2 \( \sum \) No
VITAI ysician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2  No  Hospital: 1 Inpatient	2 ER/Outpatient	Othor	e of Death (Check		ce 6 Other (Spe	opife)
n or ding Ph h. After th funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Day, Yea	28b. Time of	28c. Injury a work?	at :	28d. Describe how		Schiy)
DIVISIO al or Attender set after deat al Director. ed in by the	Certificate:	2  Accident Investigation 3  Suicide 6 Could not be 4  Homicide determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, streed pecify)		es 2 🗆 No	28f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
the Hospit thin 24 hour the Funera	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my keep conduction on the basis of examination on the basis of examination of examination of the basis of examination of	nation and/or investi	gation, in my opinion, death occurred at the	, death occurred at e time, date and pla	the time, date and ice, and due to the	place, and due to the cause(s) and manner	e cause(s) and manner stated. as stated.
		29b. Signature and title of certifier  Mou ho-ad BA771, MD-	HE		1 2 4	. ^	d. Date signed (Mor	
			(Item 23a) (Type, Pr	10,217	40			
Sta Registr		31. Date filed (Month, Day Year) 2012 32. (egistrar's S	signature					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

Haberestown

1115PM

OGBBER 2

4c. County of Death

Washington

Physician/ Medical **Examiner** 

1 - For State Registrar

Franklin

4a. Facility Name (if not institution, give street and number)

Julia Marior Health cape

Beckley Carbaugh

다 한 교육	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show a permy injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director		215-18-2895 Usual Residence of Decedent 10a. State 10b. County Maryland Washi 10e. Street and Number 333 Mill Stree 11. Marital Status	215-18-2895  Usual Residence of Decedent  10a. State  10b. County  Maryland  Washington  10e. Street and Number  333 Mill Street  11. Marital Status  12. Was Decedent Example Force?	215-18-2895  Usual Residence of Decedent  10a. State  10b. County  Maryland  Washington  10c. City, 7  Maryland Washington  Ha  10s. Street and Number  333 Mill Street  11. Marital Status  12. Was Decedent Ever in U.S.	215-18-2895  Usual Residence of Decedent  10a. State  10b. County  Maryland  Washington  10c. City, Town or Location  Hagerstown  10c. Street and Number  333 Mill Street  12. Was Decedent Ever in U.S.  13. Was Decedent Cub	215-18-2895  Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. City, Town or Location  Hagerstown  10c. Street and Number  333 Mill Street  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sp. Armed Forces?)	215-18-2895  Usual Residence of Decedent  10a. State  10b. County  Maryland  Washington  10c. City, Town or Location  Hagerstown  10g. Street and Number  333 Mill Street  12. Was Decedent Ever in U.S.  Armed Force?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hispanic Origin? Origin? (Specify Yes or No-Hispanic Origin? (Specify Yes Origin? (Specify Yes Origin? (Specify Yes Origin? (Specify Yes Origin? (Specify
23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respir shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)	other than "natural", or items ent, the Medical Examiner mu	Be Completed by	11. Marital Status	12. Was Decedent Ev Armed Forces?  1 X Yes 2 N If Yes, Give Year or Dates 19  2's Education it grade completed)  College (1-4 or 5+	43-19	13. Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto Specify: pation during most of work)	Rican,	etc.)
23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respirator, shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury tresulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Characteristic proposed by the conditions of the conditio	rmit, Page 1 and 2 should be in partment of Health and Mental portant: If item 27 is marked y injury or other traumatic ev <u>ce.</u>		19a. Informant's Name/Relationsh  Ecile B. Shaw  20a. Method of Disposition  1 ◯XBurial 2 ◯ Cremation  4 ◯ Donation 5 ◯ Other (St	p (Type, Print) Friend  3 □ Removal from State pecify)	20b. Place ceme	1301 Cedarwoo e of Disposition (Name of metery, crematory or other pla Hill Cemeter	Clara and Number or Run d Drive, ce) 10-26	Vic Pal Route Num Hagers Date 5-12	ol st
24a. Was auto performed to medical examiner?  25. Was case referred to medical examiner?  1   Yes   2   No	ı	ın/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End a Due to (or as a c b. Due to (or as a c c. Chrow Due to (or as a c d.	consequence	Demontia Ce of: Destructive ce of:	with Be Diseas Dulmi	ihaviti e	
26. Place of Death (Check only one)  27. Manner of Death  Natural  Accident		ompleted by Physicia	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant condition	4 ☐ Pregnant at t 9 ☐ Unknown  s contributing to death but	time of deat	th 5 ☐ Other (specify) _ ng in the underlying cause g	ven in Part I.	23e. Did to	rn
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause only one)		To Be	examiner?  1	1 ☐ Inpatien 28a. Date of injury (Month, Day, Validon	Year) 28t	Outpatient 3 DOA Oth b. Time of injury M 28c. Injury wor	er: 4 A Nursing Ho	k only one) ome 5  Resid	enc

State Registrar

OCT 8 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ X toper 6:55 M ELAINE ARSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON HAUERSTOWN MERITUS HOSPITAL HAGERSTOWN 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Security Number -32-4369 **Funeral** 80 Months Hours Country)
MD 10-17-1932 1 □ M 2**X** F **Director** 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Washington Big Pool 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21711 12612 Pecktonville Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married Specify: white þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mactical Conce. residence Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker <u>12th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bruce Elwood Shives ပ Edna Louise Miller 19a. Informant's Name/Relationship (Type, Print)
Penelope Horst d 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13304 Big Pool Rd. Clear Spring, MD 21722 daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 10-25-201 Parkhead Cem. 1 X Burial 2 Cremation 3 Removal from State Big Pool, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licensee CH P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ HEMORRHAGIC STROKE WITH clau disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MYELOB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir attending physician and I for use as the burial-transit BILATERAL HIP Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION Due to (or as a consequence of): Physician/Medical HYPERCHOLESTEROL DEPRESSIO STE OPOROSIS The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MYELDBLASTIC LEUKAEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? è 1 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🗆 Certificate: 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined. City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of certil 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MERTIUS

egistrar's Signature

EMICHIE

HOSPITAL HAGERSTOWN

MΩ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

MONIKA JAN 2. Date of Death 3. Time of Death JANINE CHRISTIANI 15<sup>Day</sup> Physician/ o℃T. 2012 2:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12362 BOARMAN ROAD NEWBURG CHARLES Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 578-84-5557 Hours 55 **Director** 1 - M 2XX 06-19-1957 FRANCE Usual Residence of Decedent d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director NEWBURG CHARLES 1 Yes 2 X X0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12362 BOARMAN ROAD Funeral 20664 UNITED STATES within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XX o Specify: If Yes Give 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GAINT Elementary/Secondary (0-12) College (1-4 or 5+) CASHIER 12TH (GROCERY STORE) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked or any injury or other traumatic ever LEONARD EDWARD VALLEY ERIKA C. MARCHEWKA VALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,\,33904$ RITA M. BEARDEN / SISTER 110 SOUTH EAST 42ND ST., CAPE CORAL, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCT. Date 17, RIVERDALE PARK CREMATORY 1 ☐ Burial XXCremation 3 ☐ Removal from State RIVERDALE, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service License TERRENCE L. JOHNSON FUNERAL SERVICE, 4433 WHITE PLAINS LANE, WHITE PLAINS. TERRENCE JOHNSON#M00993 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death NCER Ph.siri\_n Co disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be 68760 as the l IF FEMALE: ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Vear Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENSION Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifics director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident
3 Suicide filled in by the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026064 10-16-2012 10583. THEODORE GREEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YASAGAR NMANGAND 31. Date filed (Month, Day, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ oct.17, 2012 Vicente Canales Reyes 1900 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 082-70-9181 490471922 El Salvador Director 1 🖾 M 2 🗆 F 90 2 should be filed within 72 hours after death with the Mayland th and Mental Hygiene.
27 Is marked other then "natural", or items 23a or 28a s show treumatic event, the Madical Eventiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12100 Atherson Drive El Salvador 20902 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No f Yes, Give 1 ¥ Yes 2 □ No Specify: Baltimore, Maryland 21215-0036 Salvadoran White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Silvano Reyes Herrera Trinidad Canales Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12100 Atherson Drive Silver Spring, Md20902 Damaris Reyes/Daughter item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 e Department of H Important: If ite any Injury or ot cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 10/27/2012 Silver Spring,Md Gate of Heaven 4 Donation 5 Other (Specify) 21. Signature Wineral Service Lice L PHILLIP ADERTHULDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary embolism disease or condition Medical resulting in death) Due to (or as a consequence of) <sup>'</sup>Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit Acute coronary syndrome Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Day Yea 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed?
Yes 2 🔀 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2🔀 No ည 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c, Injury at work? 1 □ Yes 2 □ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accident 3 🔲 Suicide 4 🔲 Homicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) D067279 Oct.18,2012 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Alagarsamy Veerappan MD 1500 Forest Glen Drive Silver Spring, Md 31. Date filed (Month, Day, Year, State 32 Registrar's Signature 23 2012 backs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #31 per FCHD TM 10/23/12
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 19 2012 11:20AM Medical David Lee Coblentz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick <u>Frederick Memorial Hospital</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Age (In vrs. last birthday) (Month, Day, Year) Days Director 214-66-0692 1 X M 2 D F 03/13/1954 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 X Yes 2 No Frederick Middletown 10e. Street and Number 10g. Citizen of What Country? Funeral 208 South Jefferson Street 21769 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 X Married Š Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clergy Religion other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Walter Lee Coblentz Thelma Mae Swomley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Coblentz / wife 208 S. Jefferson St., Middletown, MD 21769 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⚠ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Reformed Cem. 10-23-2012 | Middletown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 'ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) ed by the a g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. burs after death. eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? ۾ Records, Completed 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined e Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) unfaux MDD 67950 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. SEVENTH ST. FREDERICK, MD 0 400 UDUG-AMPOLA-STEWART 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2

8

october

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35927 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 14, Robert McGee Cannon 2012 1:23 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 4526 Araby Church Road Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country. Director 577-38-5321 1 X M 2 □ F 81 Oct. 4, 1931 Washington, DC Usual Residence of Decede 2 should be filed within 72 hours efter death with the Maryland the end Mentel Hyglene.
27 is marked other then "neturel", or Items 23e or 28e-f show traumatic event, the Macked Evaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4526 Araby Church Road 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Korean Year or Dates. War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Ś 1 ☐ Yes 2 X No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lithographer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Guilford Cannon Leslie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5533 Boyce Dr., Alexandria, VA 22311 Dorothy Cannon Johnson/Daughter Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2012 Frederick, Maryland 21. Signature of Funeral Service Licensee Restnaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition resulting in eath) Physician/ wound aun Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any heading to immedicause. Enter Underlying Cause (Disease or injury Due to lor as a consuluence of Exami the attending physiclan and ched for use as the burial-transit lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day ate hes been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy certificate Yes 2 N To the Hospitel or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☑ No Victim ☐ Accident 14,2012 Unknown Investigation 3 X Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Toyrn, State) determined home a7 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in the policy of the cause (s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1cx ass of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month,

Baltimore, Maryland 21215-0036

Box 68760

**Division of Vital** 

DME

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death october Physician/ ran 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical nne 1001 If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe **Funeral** Days Min. Hours 478 36 3496 Director 1 ☐ M 2 🔀 F 78 Yrs July 25, 1934 Iowa Usual Residence of Deceden show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🏋 Yes 2 □ No Iowa Calhoun Lake City ö 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a by Funeral 520 North Hancock Street 51449 USA ural", or items ? I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify:White If Yes, Give "natural" 3 - Widowed 4 - Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Allen, Sr. Francis Burnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Daryl Crandall 520 North Hancock Street, Lake City, IA Husband 51449 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1; cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory10/20/2012 Alexandria, VA 21. Signatur of Funeral S 22. Name and Address of Facility Advent Funeral Services M00839 42 Hudson Street, #110, Ann
Part 1 Enve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 42 Hudson Street, #110, Annapolis, MD Approximate Interval Between set and Death Immediate Cause (Final Physician/ SITUC disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Man Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atter Id be detached for in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has death? within 24 hours after death.

To the Funeral Director; After this certificate h
completely filled in by the funeral director, page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Hospital Other: မ 1 🗌 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending work?
1 \sum Yes 2 \sum No 1 🔯 Natural 5 Pending injury Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ecrtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 65.1 30. Name and address of person who completed cause of State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Registrar

State

Ajit Kurup,

MD

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Francis A. Cooch, III Month 4:52 A 2012 Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Arbor at Baywoods Annapolis Anne Arundel Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Days 221-12-0475 Hours **Director** 89 1XXM 2 - F July 28, 1923 Delaware Usual Residence of Decedent 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7101 Bay Front Drive, #510 or items 23a 21403 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: "natural", White Completed 3 Wildowed 4 Divorced 1944-73 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** I Hygiene. Colonel U.S. Army permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis A. Cooch, Gladys McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Cooch/son 1460 Ritchie Highway, #212 Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery Unk. Arlington, Virginia 22. Name and Address of Facility John M. Taylor Funeral Home Signature of puneral Service License 6 147 Duke of Gloucester St., Annapolis, MD 21401 add 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Parkinson's Disease disease or condition resulting in death) years Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exease or injury Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal usa Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year ed by the a 9 Unknown P.O. been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 🗆 No Yes 2 X No 1 Yes Hospital or Attending Physician: 24 hours after decth. Funeral Director: After this certific Division of Vital funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2**XX**No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 XX lursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident
Sulcide Investigation filled in by th. Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours
To the Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21438 October 22, 2012

Registrar DHMH 17 Rev 06-2011

State

Annapolis, Maryland

445 Defense Highway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rg

Michael J. LaPenta, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas J. Collins 2012 8:59 P Medical October 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 78 Robinson Landing Road Anne Arundel Severna Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Director 212-42-4503 1 X M 2 - F Yrs 69 3-13-1943 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severna Park 1 🗌 Yes 2 🛭 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 78 Robinson Landing Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. ģ 1 X Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiana. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) County Government Maintenance 12 should ba filed walth and Mental Hyg 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleveland Collins unknown parmit. Paga 1 and 2 should I Dapartment of Haalth and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Robinson Landing Rd. Severna Park, MD 21146 Jeanne Davenport / friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State important: if it any injury or o 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10-18-2012 Baltimore, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Betwee Immediate Cause (Final D Q Physician/ disease or condition resulting in death) Medical Dug to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) aral Director: Aftar this cartificata has baan signed by the attanding physician and filled in by tha funeral diractor, paga 2 should ba datached for usa as tha burial-transit Hospital or Attending Physiclan: Tha law raquires that tha daath cartificata be axecuted ause (Discase of rigury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 110 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Desidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of s aftar death. I Director: Aftar t 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospitai within 24 hours ( To the Funaral () completally filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 who completed cause of death (Item 23a) (Type, Print) 31. Date legistrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frank A. Clancy, JR. 2012 October 0 4:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Hours **Director** b94-52-<u>6064</u> 1 🛛 M 2 □ F 54 April 28,1958 New York Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 
Y Yes 2 □ No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 12227 Foxhill LN USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the <u>Systems Engineer</u> TRI TECH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank A. Clancy, SR. Arlene Weimann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau Vickie Clancy /Wife <u> 2227 Foxhill LN. Bowie MD. 20715</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State **Department** Huntt Crematory 10/20/2012 Waldorf, Maryland 4 Donation 5 Other (Specify) 21. Signature of Faneral Service Lice 22. Name and Address of Facility Robert E. Evans Funeral Home. 6000 Annapolis Road, Bowie, Maryland 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) C 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months? Month Year Dav 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) xamine? 2 🗌 No မ npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Mo gistrar's Signature OCT 1 9 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dianna Sonia 🤇	Collig	1- For State	tate of Maryla	•	artment of		Mental Hy	_	eg. No. 2	012 359	) ;	
Physic	:ian/	1. Decedent's Name (First, Midd	ile,Last)		141			2. Date of Dea	Date of Death  3. Time of Death			
Medical Exan	nine	Didia D.	Colligan	_				October 1	4, 2012	1037 hrs		
4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  613 Twin Tree Road  Salisbury						4c. County of Death Wicomico						
E		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hidhday)	If Under 1 Year	If Under 24Hrs.	R Date of Bir		Birthplace (State or	_	
Funera Directo		216-36-6001		7. Age (III yis. )	-	Months Days	Hours Min.		,	Foreign		
	•	Usual Residence of Decedent	1 M 2 X F	/3	Yrs.			09/01	/1939	9Maryland	_	
any		10a. State 10b. County		10c. City	Town or Location	on				10d. Inside City Limits	s	
nd show	=	Maryland Wic	omico	Sa	alisbury	•				1 Yes 2 X No	0	
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?	_	
72 hours after death with the Maryland ne "uatural", or items 23a or 28a-f sho at East at once.	ä	613 Twin Tre	e Road			21801			USA			
h with	Funeral	11. Marital Status  1 Never Married 2 X M		dent Ever in U		Decedent of Hispa s, specify Cuban, I			- 14. Race - White,	- American Indian, Black,		
or its	F		1 Yes	2 <b>X</b> No				(toda), Gto.)				
rs afte ural",	<u>۾</u>	15.5	vorced If Yes, Give Yeer or Dates:	completed)		Yes 2 X No		ork done	Specify: 16b. Kind of Busi	White	_	
2 hou	Completed	Elementary/Secondary (0-12)			during mo	st of working life.	OO NOT use retir	ed)	TOD. KING OF BUS	mess/middsity		
036 ithin 7 ne. r than	Jdu	12	4		T∈	acher			Educat	cion		
5–0036 iled within 72 hours afte Hygiene. In ther than "uatural", the Medical Examine:	ပြ	17. Father's Name (First, Middle	, Last)			18	3.Mother's Name	(First, Middle, M	Maiden Surname)	·	_	
21218 Duld be fill Mental H marked i	B	Frances Raska					Sophia					
	P	ſ			1	Address (Street						
- P = = =		Wendy Bunting 20a. Method of Disposition	/Daugnter	20b.	706 Place of Disposit	ion (Name of ceme		Date	MD 2184	€∠ City or Town, State	_	
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation	_	m State	crematory or oth		.	17/2012		oury, MD		
Itimen artmen britani		4 Donation 5 Other States 21, Signature of Funeral Service	pecify:	1 30						-	_	
Balti permit. Departm Imports	L	Kett.			THO 50	lloway F l Snow H	uneral F	lome Pro	ofessiona	al Association	n	
Physician		23a. Part I. Enter the disease, or		used the death						t Approximate Interva		
/Medical		failure. List only one cause Immediate Cause (Final disease	_	ne Into	xicatio	n				Between Onset and Death		
-xaiiiiici		or condition resulting in death)	Due to (or as a c								_	
	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a c	onsequence o	f)·						_	
	ij	cause. Enter Underlying Cause	c		.,,							
ed	Examiner	events resulting in death) Last	Due to (or as a c	onsequence o	f):							
O, be executed sician and ourial - transi	dical	X UNPENDED	a AMENDED 2:	3a,27,2	8a-f,pe	r me,g933	3 11–14–	-12 sm				
760 icate b physi		IF FEMALE: 23b. Was decedent pregnant in the		tcome of pregi			1800-00		23d. Date of d		٦	
lox 6876C leath certificate Is attending phys for use as the bi	Sia	past 12 months?	I I TIME DIL	th nt at time of de	ath -	ll death 3 er (S <i>pecify)</i>	Ectopic pregnar	icy	Month	Day Year		
Box 6876( e death certificate the attending phy- ed for use as the b	Physician/M	1 Yes 2 No 9 V Uni		'n	J Oth	gi (Specify)			9).		1	
ires that the disigned by the loe detached	by P	Part II. Other significant condit	ions contributing to	death but not re	esulting in the un	derlying cause give	en in Part I.			ute to the cause of death?		
Division of Vital Records, P.O tal or Attending Physician: The law requires that the stafer death.  and Director: After this certificate has been signed by the funeral director, page 2 should be deaced.										Probably 4  Unknown		
cords, law requir	Completed			, 				24a. Was a autop:	sy pri	ere autopsy findings available or to completion of cause of	4	
Rec The la	É							perfor 1 ✓ Yes		ath? ✔ Yes 2 No		
tal Rection: The certificate ector, page	BB	25. Was case referred to medica examiner?	He spital:				Death (Check o				_	
F Vit Physic or this	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp		ER/Outpatient				Residence 6		_	
on of ading Pl th. : After e funera	.io	1 Natural 5 Pend	(Month, E	Day,Year)	28b. Time of Inj	1 Ve	s 2 X No		ow injury occurred			
isio	icat	2 Accident Inves	stigation Id IU	-14-12		factory, office buil		<u>oveřdos</u>	ed		_	
Divi	Certification:		d not be (Specify)		Family			or Town, St Salisbu	ate) 613 Tw	or Rural Route Number, City in Tree Rd.		
Division of Vital Records, P.O. Box 6876( To the Hoppital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Directur: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier 1 CertifyIng Pt	nysician: To the best of miner: On the basis of	of my knowledg	e, death occurre	ed at the time, date	and place, and o	lue to the cause	e(s) and manner a		_	
To To com	Me	29b. Signature and title of certifie	and manner sta			29c. License r				(Month, Day, Year)	4	
		ano R				O.C.M.	E.		October 15,	2012		
_		30. Name and address of person	who completed cause	of death (Item	23a)						-	
		Ana Rubio M.D., Ph. [	-			V. Baltimore S	Street, Baltim	ore, MD 21:	223			
S Regis	tate strar	31. Date filed (Month, Day, Year)	1012 Regi	strar's Signatu	bark							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death :32 Charlotte Rose Craft 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death rsina 8. Date of Birth (Month, Day, Year) 8/20/1941 9. Birthplace (State or Foreign Country) VA If Under If Under yrs. last birthday) 1 □ M 2 🛣 F Months Hours 218-40-2069 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 ☐ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 415 Market Street USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aryie R. Wyatt Sr. Hazel L. Idol 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Wyatt / sister 1121 A. Vanguard Way, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 10/29/2012 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Nottingham Cemetery Colora, MD Signature of Funeral Service License 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

မ

**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and d for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed
thin 24 hours after death.
 the Funeral Director: After this certificate has been signed by the attending physician and
impleted filled in by the funeral director, page 2 should be detached for use as the burial-transit s been signed by the should be detached within 24 hours after de:

To the Funeral Director

completed filled in by th

Division of Vital Records, P.

	shock, or heart failure. List only one	ications that caused the death. Do not enter the anode of dying, such as card e cause on each line.	diac or respiratory arrest,	Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition	INEU MORY A		Onset and Death				
	resulting in death)	Due to (or as a consequence of):						
<u>r</u>	Sequentially list conditions,	Due to (or as a consequence of):						
Ĭ.	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of).		72				
Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):						
dical		d						
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 10 No 9   Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery  Month Day Year				
ted by Ph	Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I.	1	use contribute to the cause of death?				
Complet			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 No				
Be	25. Was case referred to medical examiner?	26. Place of Death (0	Check only one)					
2	1 Yes 2 Yo	lospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursir	ng Home 5 🗆 Residence (	6 Other (Specify)				
Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury Work?  M 1 Yes 2 No		28d. Describe how injury occurred				
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	nd Number or Rural Route Number, e)					
<b>Nedical</b>	(Check 2 Medical Examin	cian: To the best of my knowledge, death occured at the time, date and placer: On the basis of examination and/or investigation, in my opinion, death occure Practioner: To the best of my knowledge, death occurred at the time, date and	rred at the time, date and place	e, and due to the cause(s) and manner stated				

29d. Date signed (Month, Day, Year)

21078

State Registrar

3

29b. Signature and title

30. Name and addre

31. Date filed (Month, Day, Year)

ed cause of Path (Item 23a) (Type, Print 2)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#7and#8perfuneralhome10/19/2012/cchd/ba

Certificate of Death

Reg. No. For State Registrar 1 Decedent's Name (First Middle | ast) 2. Date of Death Time of Death Month 0 Physician/ Day 2012 onia ameror Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Regional aurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number ( Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 60<sub>Yrs</sub> Hours 237 94 0036 NC Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MD Yes 2 No -aure Trince 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11694 20 708 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married hours after Yes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Black If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance 10th Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown Dorothy Cameron 19a. Informant's Name/Relationship (Type, Print) Hazel R. Cameron/ sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $10009\,$  212 E 7th St. Apt 204 New York, New York permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or care 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Iæ Memorial Gar 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gard. 10/22/12 Sanford, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf MD 20601 Signature of Funeral Service Licensee remerce onic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on. To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ v 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Unknown 1 Yes 2 No 3 Probably 4 Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 2 No within 24 hours after death.

To the Funeral Director; After this certificate Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-201

State

31. Date filed (Month, Day,

M

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

1 9 2012

Laurel Regional Hospital,

7300 Van Dusen Road

Emergency

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Day</sup> 2012 Guy Wilson Covert, Jr. 4:45pM Oct Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Dove House Hospice Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 220-22-5634 Director 1 X M 2 □ F 83 2/22/1929 MD 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Carroll MD Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1421 Burnside Drive 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian XYes 2 No 1948 – Yes, Give Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Divorced 1952 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4 or 5+) police officer Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Guy Wilson Covert, Sr. Lydia E. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health itam 27 Joan A. Covert, wife 1421 Burnside Drive, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If its
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) carroll Cremation 10/5/2012 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral M00741 934 S. Main St., Hampstead, MD21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final TIBrosie Physician/ Monard years disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day 1 Yes 2 No signed by the a lid be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1/12/Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, pag perform 2 🗌 No 1 Tes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) P Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Xertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title or certif 29d. Date signed (Month, Day, Year) 0102 12+ Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony T. Crone 12:30 p<sup>M</sup> 2012 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North Pines Assisted Living Manchester Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-42-8385 Months Days Hours (Month, Day, Year) **Director** 1 XM 2 □ F 67 Dec 16, Maryland Yrs 1944 Usual Residence of Decedent show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified Westminster Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. It has 23a or item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be other traumatic event, the Medical Examiner must be 21158 Funeral 1700 Indian Valley Trail USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Viet Nam
Year or Dates. Black, White, etc. þ 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Phone Company Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lawrence J. Crone, Sr. Mary Elizabeth Henning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Indian Valley Trail, Westminster, MD 21158 Michael Crone, nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Ganne) Sonate (One State) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2012 Owings Mills, MD Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ ERCATOTEMPORAL DEMENTIA (PICK'S DISSA 34500 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): burialnding physician Physician/Medical death certificate be Box 68760 the as IF FEMALE Jse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, RHEUNATUS ARTURITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings avallable prior to completion of cause of death? 1703 24a. Was an page 2 performed 1 Ves 2 No certificate Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) \_2 🗷 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Alatural 5  $\square$  Pending Accident n 24 hours after death.

e Funeral Director: Ai 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🐣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) è DITUHU 1015/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 VA 215 Washington Hts Med Ctr Westminster MD 21157 M.D anham. egistrar's Signature 32 State

Registrar

DHMH 17 Rev 06-2011

College.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Ple	ase Type or							_	ible.		
		ForState	State	of Marylan		artment of H		and M	lental Hy	giene	0 1 0	00020	
		Registrar  1. Decedent's Name (First, Midd	lie Last)		Cer	tificate of D	<i>peatn</i>		2. Date of Dea	Reg. No.		3593C	
Physicia Medic	al	PEARL CL	INE C	HAVES	pr-				10 Month E	Day 201	2 <sup>Year</sup>	3. Time of Death 2D12_M	
Examin	er	4a. Facility Name (if not institution VNIV. OF MARYLE			TER	4b. City, Town, or BALTI	Location of			4c. County	of Death		
Funeral Director		5. Social Security Number 225–30–4326	6. Sex	7. Age (In yrs. la	-	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h /, Year)	9. Birthp Count	lace (State or Foreign ry)	
		Usual Residence of Decedent	1 □ M 2 <b>X</b> F	85	Yrs.		L		July 2	5 <b>,</b> 1927		rginia	
ryland -f sho ied at	Director	10a. State 10b. Count	roll	10c. City	y, Town or Loc	cation	Mos	tmin	ctor		11	0d. Inside City Limits  1 X Yes 2 \( \square \) No	
the Ma or 28e	<u>pi</u>	Maryland Car  10e. Street and Number	1011			10f. Zip Code	WCD	CILLIA		10g. Citizen of V	Vhat Coun		
n with	Funeral	205 Saint Mark	. Way, Apt	502			211	58			USA		
r death r item iner n		11. Marital Status 1 ☐ Never Married 2 📈 Ma	Armed F	edent Ever in U.S orces?	5. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Ori n, Mexicar	gin? (Spe ı, Puerto	cify Yes or No- Rican, etc.)		e - America k, White, e		
urs afte ural", o	ted by	3 Widowed 4 Divorce	d If Yes, Gi Year or D		1	☐ Yes 2 X No	Specify:			Specify:	wh	ite	
72 hor n "nat Aedica	Completed	(Specify only high	ent's Education nest grade completed		(Give F	ent's Usual Occupa kind of work done d O NOT use retired)		t of worki	ng	16b. Kind of Bu	usiness/Inc	lustry	
within giene. er tha		Elementary/Secondary (0-12)	College (	1-4 or 5+)		ecretary				U.S. (	Gover	nment	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Roy Cline	Last)						e (First, Middle, Rexrud	Maiden Surname <b>C</b>	)		
id 2 shoul saith and I n 27 is me er traums		19a. Informant's Name/Relation				g Address (Street a St Mark V							
Page 1 an Jent of He Int: If iten		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other				sition (Name of pat <b>alypew</b> her place in Cemete)			Date 5/2012	20c. Location -	-		
permit. Departing Imports any inju		21. Signature of Funeral Service	Licensee	MAUS		. Name and Addres	s of Facilit	y My Wes	ers-Dur	boraw Fi	ınera 1157	1 Home	
		23a. Part 1. Enter the disease, of shock, or heart failure. List	or complications that	caused the deatl	h. Do not ente				-			Approximate	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. SVBD	VRAL F		TOMA D	VE	TO	FALL			Interval Between Onset and Death	
Examiner			Due to	(or as a consequ	ience of):					///	/		
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  C.  C.  Due to (or as a consequence of):							AL EXAMINER	1			
be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):	-15	CHION	APPRO	NED BY MILDI	01.1-	1		
cate be physici s the bu	edical		d			Ct KJII	HUNITY				_		
eath certifica attending pl for use as t	an/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna Birth 2  Feta		Ectopic pregnanc	1			23d. Da	te of delive	ery	
the death by the atter	hysici	in the past 12 months? 1  Yes 2 No 9 Unknown		gnant at time of c		Other (specify)	у			Mo	nth	Day Year	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medic	Part II. Other significant condit	ions contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part	l. 	23e. Did to	5.0		e cause of death?	
The law req ate has bee page 2 shor	omplet								24a. Was a autop perfo	rmed?	orior to cor death?	osy findings available impletion of cause of	
sician: The certificate l irector, pag	Be C	25. Was case referred to medica examiner?				26. Pla	ice of Dea	th (Check		2 AJ No	I ☐ Yes	2 L No	
Physic this ce ral dire	유	1 Yes 2 □ No	Hospital:	Inpatient 2	ER/Outpatien		4 ∐ Nı			ence 6 🗆 Othe			
nding F th. : After e funer	cate	27. Manner of Death  1 ☐ Natural 5 ☐ Pend 2 ☒ Accident Invest	ing 28a. Date (Mor	of injury oth, Pay, Year)	28b. Time of injury	28c. Injury work: M 1 🗆	at ? Yes 2.⊠X		28d. Describe h	ow injury occurre		HUDING	
or Atter after des Director in by th	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 286 Place	e of Injury - At ho ling, etc. (Specify	me, farm, stre	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State) 205 ST MARK WAY WESTAIN STE				
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier 1 Certifyin (Check 12 Medical	g Physician: To the ba	best of my knowl	edge, death o	ccurred at the time	, date and	place, ar	nd due to the ca	use(s) and manr	er as state	ed. Ise(s) and manner stated.	
To the ly vithin 2 to the le complet	Me	only one) 3 Certifyin 29b. Signature and title of certifie	g Nurse Practitione	r: To the best of m	ny knowledge,	death occurred at the 29c. License	ne time, da	te and pla	ce, and due to t	ne cause(s) and n 29d. Date/signe)	nanner as s	tated.	
		> M	MS			102	292	>		. / - /	201		
NAS		30. Name and address of person	who completed cau	se of death (Item	23a) (Type, P	rint) BALI	IMO	RE	MY	> 212	01		
State Registra	_	31. Date filed (Month, Day, Year)	2012	Registrar's Signat	d. for	ake							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35939 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Wayne Bishop Durney <sup>Day</sup> Мд October 2012 1:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince George Hospital Cheverly Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 219-76-3572 **Director** 1**X**] M 2 □ F Yrs. 45 1967 July 23, Maryland 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 1 🗆 Yes 2 💢 No Charles LaPlata Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Teresa Lane 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Elevator Mechanic Elevator Company other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Thomas E. Durney, Sr. Lillie Porter permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 6336 Teresa Lane, LaPlata, Md. 20646 Peggy C. Durney Baltimore, 23, Data 2012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placeOcti. 1 XBurial 2 Cremation 3 Removal from State Suitland, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery 22 Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head. 20640 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest re. List only one cause on each line. Part 1. Enter the di shock, or heart fail Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examin burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 phys the t use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed? 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ည ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: After bletely filled in by the fur Division Investigation Accident 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) DITOI egistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Dudley Juanita October 20, 2012 5:38 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death 5000 Lydianna Lane; Apt. 307 Suitland Prince Georges Age (In yrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year 1939 Director 579-54-4155 72 1 🗆 M 2 🗶 F Washington, D.C. December 4. show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits be notified 28a-f Maryland Prince Georges Suitland 1 X Yes 2 No 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5000 Lydianna Lane; Apt. 307 20746 United States death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 X No 10. Black, White, etc Completed by 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black If Yes, Give Year or Dates "natural" 3 Divorced 4 Divorced d other than "natur event, the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry
US Dept.of Treasury/ (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 years Elementary/Secondary (0-12) Mental Hygiene. Accountant Bureau of Engraving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental F item 27 is marked o other traumatic eve ၉ Jones Linwood Dudley Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Lydianna Lane; Apt. 307; Suitland, Maryland 20746 Kimberly Ann Dudley (Daughter) item 2 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or of ō X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEMETERY Suitland, Maryland ignature of uneral Ser **4**21 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease, or complication of Immediate Cause (Final Physician/ 18 months Metastatic Breast Cancer Medical resulting in death) Examiner Stage II Left Breast Cancer 52 months Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burialnding physician Physician/Medical death certificate be P.O. Box 68760 ISe S 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) į in the past 12 months?

1 Yes 2 X No been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 perform death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No e Hospital or Attendi 124 hours after death e Funeral Director; A Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State

3500

the within 2 To the F

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

only one)

31. Date filed (Mo

3 [

29b. Signature and title of certifier

aster

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane

Registrar's Signatu

■ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DZ6250

Largo, Maryland

29d. Date signed (Month, Day, Year)

23, 2012

October 0

20774

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

#	18,20h	23	a mar											ii Copi		_	ible.		
	ided 10		For IOI.	HD, 10/	26/ /15/	<b>≱(⊞[€</b> 20 / 2 ∩ 1 2	or Mary דידיכ	/land		artmer <i>tificat</i>			and iv	ientai H		2	n L	35	94
Amen	ided It	JC	Registrar I C     Decedent's Name			2012	, 110	)	Cei	uncat	e or L	Catri		2. Date of I	Reg. It	No	0 1 2	3. Time of D	
	Physicia Medic		DOMINICK DANZO										Month OCTODE	< 1º	Day 21	Year	1740		
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death																			
	Forestel		MEMORIA HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)								EASTON  If Under 1 Year If Under 24 Hrs. 8, Date of Bi					th 9. Birthplace (State or Foreign			Fornian
	Funeral Director		085-09-8			M 2 □ F	r. Age (iii		Yrs.	Months		Hours	Min.	(Month,	Day, Year) Country)			ntry)	_
	P o d	_	Usual Residence of Decedent  10a, State  10b, County				1.10	97	Town or Loc	notion.				05/21	/191	NEW YORK, NY  10d. Inside City Limits			
	arylan a-f sh ified a	Director	MD	1	вот				PORT S		ОТТАС	ЭE 11	8 I	EASTO	N			1 X Yes	
	the M or 28	Dir	10e. Street and Nun							10f. Zij					10g.	Citizen of V	What Cou	ntry?	
	h with	Funeral	700 PORT	ST. CC	_						1601		_		USA				
	r deet or Iten niner r	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li></ul>	ied 2 ☐ Marr		Armed Forces?			13. V	Vas Deced f Yes, spe	dent of His cify Cubar	spanic Or n, Mexica	igin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0-		e - Ameri k, White,	can Indian, etc.	
-0036	rs afte pral",	ed b	3 X Widowed			1 ☐ Yes If Yes, Give Year or Da	re ates.		1	☐ Yes	2 <b>X</b> No	Specify	:			Specify:	WHI	ľE	
75	72 hou	Completed	(Spe	15. Deceden				- 1	16a. Deced (Give I	kind of wa	rk done d	ation <i>Juring mos</i>	t of worki	ng	16b.	Kind of B	usiness/lr	idustry	
212 212	vithin liene. or ther		Elementary/Seco	ondary (0-12)		College (1-	-4 or 5+)		WAREH	O NOT us IOUSE		ERVIS	OR		VA	ADMI	NIST	RATION	
E B	filed valued by all Hyg	Be	17. Father's Name (		ast)	-						18. Moth	er's Name	e (First, Midd	le, Maide	n Surname	) ICCT		
Déminick Maryland 21215-	uld be 1 Ment narke netic e	2	ROCCO DA					— т				ANGE	LINA	COLUC	CI-C	AKLU			
Ma Ma	and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. Send 27 is marked other then "natural", or items 23e or 28e-f show ther treumetic event, the Markeal Examiner must be notified at		19a. Informant's Na NANCY CO			•				-	,			I Route Num TTLGHN				Code)	
Co.	of Healt of Healt fitem 2 r other		20a. Method of Disp	oosition				Ob Pla		5 ISLAND CLUB RD. TILGHMAN sition (Name of natory or other place)						20c. Location - City or Town, State			
Danza Saltimore	Page ment o tant: If ury or		1 🔀 Burial 2 4 ☐ Donation			emoval from			VARI (	CEMET	ERY			/2012		JEENS			
Danzo Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any Injury or other once.		21. Signature of Fur	_		20 VI		_	_		-							HOME,	P.A.
			23a. Part 1. Enter t	HA K										. EAS		MD Z	1001	Approximate	
	Pnysician		shock, or hear Immediate Cause ( disease or condition	rt failure. List o Final	nly one	cause on ea	ach line.		LENA								- 1	Interval Betw Onset and De	reen
	Medical Examiner		resulting in death)		<b>r</b> a.		(or as a cor	nseque	nce of):								$\dashv$	DAYS	
	Examiner	er	Sequentially list co		b.		Or as a co-		E HEA	AKT	FALL	UKE							
	uted d ansit	Examine	cause. Enter Under Cause (Disease or that initiated events	rfying injury		00010	(0) 43 4 00	risoquo	1100 01).										
	be executed sicien end burial-transit	cal Ex	resulting in death) l		C.	Due to (	(or as a cor	nseque	nce of):										
260	physic physic the b	edic			d.														
89	certific inding use as	M/u	IF FEMALE: 23b. Was decedent	pregnant	230	. If yes, out				1=						23d. Da	te of deliv	<i>e</i> ry	
Box 6876	requires that the death certificate I been signed by the ettending phys should be detached for use as the	Physician/Medio	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No			nant at tim		death 3 ath 5	Other (s		у			-	Мо	nth	Day Ye	ear
o.	at the		Part II. Other signif		ns contr		-	ot resul	ting in the u	nderlying	cause giv	en in Part	I.	23e. Die	d tobacc	use contr	ribute to 1	he cause of de	ath?
<u>8</u>	lires th	d b																bably 4 🖽 0	/
5 5	w requ	plete												24a. W		24b. \	Were auto	opsy findings avompletion of ca	vailable
O N S S C						death?	2 □ No	idse oi											
ta	icien: certific rector,	Be	25. Was case referre examiner?		Hos	spital:	_	_			Tail	-		only one)			ene materiale		
of V	g Phys	은 ::	1 ☐ Yes 2 ☐ 27. Manner of Death			28a. Date	of injury	2	R/Outpatier 8b. Time of	$\overline{}$	OA Cirio 28c. Injury	4 L N		me 5 Re 28d. Describ				Ø.	
o	ending sath. or: Afte he fun	ficat	1 Natural 2 Accident	5 Pendin Investig	ation	(Mont	th, Day, Yea	ar)	injury	м	work	? Yes 2. □	- 1						
Visi	or Atto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could in determine			of Injury - ng, etc. (Sp		e, farm, stre	et, factor	y, office				(Street a		er or Rura	l Route Numbe	er,
	spital hours a neral I		29a. Certifier 1	Certifying	Physici	an: To the b	est of my	knowled	dge, death o	occurred a	t the time	, date and	place, ar	nd due to the	cause(s)	and manr	ner as sta	ted.	
	the Ho nin 24 I the Fu	Medical	(Check 2 only one) 3	☐ Medical E	caminer	On the bas	sis of exami	ination a	and/or invest	igation, in	my opinio	n, death o	ccurred at	the time, dat	e and pla	ce, and due	e to the ca	ause(s) and man	ner stated.
							Date signed		Day, Year)	2									
	125							(Item 2	?3a) (Type, P										
	6		Kolli,	, Rain	eh	v 2	2195	2	12AC	nux	M	ST,	EA	STON	$\wedge$	4) 2	2160	1	
	Stat Registra	e ar	30. Name and addre	h, Day, Year) <b>T 1 5 2</b> 0	12	37. R	egistrar's S	Signatur	par	de d									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Charles W. Davis October 0630 A<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Director 579-34-3525 1 🕅 M 2 🗆 F District of Columbia 1930 April 1, 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Chester West Grove Pennsylvania 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 778 West Glenview Drive 19390 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 

Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ပ္ J. Windsor Davis Marie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Gausch/Daughter 512 Fox Hollow Drive, Kennett Square, PA 19348 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 a Important: If it any injury or o once, cemetery, crematory or other place Brandywine Valley Cremation Care 1 Burial 2 X Cremation 3 Removal from State October 0 4 Donation 5 Other (Specify) 2012 Wilmington, DE Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ENO STAGE CHRONIC OBSTRUCTIVE PULLIDNAMY Medical Due to (or as a consequence of) Examiner CORONAMY ACLILINY Secuentially list our little os Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). cate has been signed by the attending physician and , page 2 should be detached for use as the burial-transi ANEMIA Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical CARONIC P.O. Box 68760 KIDNEY 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy il or Attending Physician: The law s after death. I Director: After this certificate has performe 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital c 24 hours at Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051158 OCTOBER 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 moreting 9701 DRIVE VEIRS ROCKVILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 12 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17, 2012 William Thomas Edwards October 12:35 P.M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, Year 1946 Months Days Hours Min. **Director** 109-38-1637 65 1 XM 2 □ F Yrs. October 24, Virginia Usual Residence of Deceder Show 10d. Inside City Limits r then "neturei", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 Yes 2 ☐ No Prince Georges Suitland Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20746 United States 3810 Regency Parkway; Apt. 103 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 X Yes 2 No
If Yes, Give Oct.1964
Year or Dates Sept.1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 72 hours after **Black** 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. lementary/Secondary (0-12) College (1-4 or 5+) Smithsonian Institution 11th grade **Building Services Worker** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental John Coleman Grace Lorine Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 Page 1 and 2 Barbara Jean Douglas Edwards 3810 Regency Parkway; Apt. 103; Suitland, Maryland Baltimore, 20c. Location - City or Town, State Cheltenham, 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Oct.30,2012 ö 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland Signature of Juneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, M01421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer SOPHAGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami nding physician and use es the burlal-transit YPOTENSION that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown cete has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Npatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ours after death. erei Director: Aft filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 P.0. Records, **Division of Vital** Hospitel or Attending To the Hospitei within 24 hours of To the Funerei C completely filled

State

Registrar

(Check

only one)

on who completed cause of

503

29d, Date signed (Month, Day, Year)

eath (Item 23a) (Type, Print)

32. Registrar's Signature

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35944 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20 2012 Dorothy E. Edwards 8:30 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 217 34 0815 Director 80 1 □ M 2 🗗 F 09/02/1932 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Silver Spring 12 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13106 Matey Road 20906 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ģ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than \* Elementary/Secondary (0-12) College (1-4 or 5+) 12th Clerk Federal Government of Health and Mental Hygitem 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If Item 27 is marked of eny finjury or other traumatic even 90e8. 18. Mother's Name (First, Middle, Maiden Surname) ည William Monroe Sadie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Rita A. Edwards 13106 Matey Rd., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 11/02/2012 Brentwood, Maryland Ft. Lincoln Cemetery onatur of Funeral Artico Cense 22. Name and Address of Facility John T. Rhines Funeral Home Washington, 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition resulting in death) a Recurrent Uterine Cancer Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Acute Renal Failure burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown 1 Yes 2 Dunknown Pregnant at time of death Day Year à 124 hours after death. e **Funeral Director.** After this certificate has been signed I lietely filled in by the funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 🗗 No 1 Junpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖒 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier 1 🐔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60826 October 20, 2012 551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

est Glen Road, Silver Spring, Maryland

MD

Kshama Garq, 31. Date filed (Month, Day Year) 1500

Fo

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER Physician/ CHARLENE WHITNEY EDWARDS 2012 8:31 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3785 KOOGLER ROAD TRAPPE TALBOT If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Hours 374-52-9651 Director 63 1 □ M 2 🕅 F 12/30/1948 MICHIGAN 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or itame 23a or 28a-f sho the Medicel Examiner must be notified at Director MD TALBOT TRAPPE 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3785 KOOGLER ROAD 21673 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married filed within 72 hours aftar Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 🗌 Widowed 4 🗀 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 mant of Health and Mental Hygiene. ant: If itam 27 is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) GRAPHIC DESIGNER OWN BUSINESS 12 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CHARLOTTE LAMB WILLIAM WHITNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3785 KOOGLER ROAD, TRAPPE, MD 21673 RICHARD L. EDWARDS, HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dapartmant of h Important: If its any Injury or oti 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 10/15/12 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 7. 200 SOUTH 23a. Part 1. Ent.: the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ a static disease or condition resulting in death) year Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): cartificate has been signad by the attending physician and liractor, page 2 should ba datached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) Month Pregnant at time of death Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 3 2 🗆 No 1 Yes a Hospital or Attanding Physician: 24 hours aftar death. a Funarai Diractor: After this cartificiately filled in by the funeral diractor, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To tha Hosp within 24 ho To tha Funa complately f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ture and title of certifie 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

CAROLYN HELMLY, MD 508 IDLEWILD AVENUE, EASTON, MD 125 D 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

& 14, PER FH G933 11/15/12 TRT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JESSIE BENJAMIN FOSTER Mont 10/10 2012 Year 11:58 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min **Director** 396<u>-48-89</u>33 1 ₹M 2 □ F 7/25/1947 MS 65 Yrs Usual Residence of Decedent show 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD Montgomery Rockville 1
▼ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 100 First Street, 20851 USA ed other than "natural", or items event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces? Black, White, etc. BLACK 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1968–1970 1 ☐ Yes 2 X No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Telecom Engineering-TWD Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Foster ည other traumatic Cora Glass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Anna Foster/wife 100 First Street, #330, Rockville, MD 20851 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 10/22/2012 4 ☐ Donation 5 ☐ Other (Specify) Cremation Ctr of MD Hanover, MD 21. Signature / Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction Medical Examiner Pulmonary Embolism Sequentially list conditions, cause. Enter Underlying burial-lansit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 as the t nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cardiac disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tely filled in by the funeral director, page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. Le Funeral Director: After the 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending Accident work 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day) Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Gardiner, 19847 Century Boulevard, Suite 205, Germantown, MD 20874 32 Registrar's Signatu State 19 OCT Registrar

Essire Buildown Poste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35947 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29<sup>Day</sup> Month 10 Ethel Hewitt Ferrall 2012 8:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 12742 Pearson Drive Waldorf Charles **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth Valley 1 🗆 M 2 🗓 F Months Days Min Director 220-84-8731 01/20/1917 Lee, Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2X No Charles Waldorf 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 12742 Pearson Drive 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked ot ည Benjamin Hewitt Emily Redman Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Elaine McConkey / Daughter 12781 Jones Lane Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Des artment of It Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Peter's Cemetery 11/6/2012 Waldorf, Maryland 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, P.A. 21. Signature of Funeral Service Licenses M00817 centro 30195 Three Notch Road Charlotte Hall 23a. Part 1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he include. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final Physician/ CEREBROVASILLAR ACC: DENT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DER TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and I for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 욘 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide
Homicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours of To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 44436 Wh 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rme

KUMA

NOV 0 1

Records,

of Vital

Division

Registrar DHMH 17 Rev 7/2009 102

ALL Mellow (T

WAYDORF

MM 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2012 Year THERESA FORD DOROTHY 1755 October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY HOSPITAL SILVER SPRING HOLY CROSS Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Min 578-52-2154 Hours 83 Director 1 🗆 M 2 🕱 F 2-28-1929 DC 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No DISTRICT HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2305 SENATOR AVE 20747 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. "natural", or δ ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: BLACK Completed 3 X Widowed 4 Divorced Year or Dates er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the 9TH HOUSEKEEPER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES SPRIGGS SADIE HENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA TURNER/ DAUGHTER DISTRICT HEIGHTS, MD 20747 2305 SENATOR AVE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o 1 XBurial 2 Cremation 3 Removal from State RMONY MEMORIAL 10-29-12 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service License 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 401089 23a. Part Y. Enfer the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ACUTE RENAL FAILURE ase or condition Medical resulting in death) Due to (or as a consequence of): Examiner SMALL BOWEL OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of,: or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burlal-transi Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILURE Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day 1 ∐ Yes 2 X No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been si e funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, æ 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 🔯 No မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27 Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 60 550 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 FOREST GLEN ROAD 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

12-08218	Please Type or Print in Black Indelible									
Wilmer Fulgueras	State of Maryland / Department of Certificate of Registrar.  1. Decedent's Name (First, Middle,Last)	of Death	giene  Reg. No. 2 0  2. Date of Death	2 3595						
Physician/ Medical Examine			Month Day Year October 30, 2012	1350 hrs						
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dear							
	1600 Doral Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bowie  If Under 1 Year   If Under 24Hrs.	Prince Georg  8. Date of Birth(MM/DD/YYYY) 9. B.							
Funeral Director	216 00 7000	Months Days Hours Min.	Fore	ign Philippine ountry)						
	Usual Residence of Decedent		00/20/17/1							
W any	10a. State   10b. County   10c. City, Town or Loc   MD   Prince George's   Mitch	ation e11vi11e		10d. Inside City Limits  1 Yes 2 No						
ryland a-f sho f once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou							
hours after death with the Maryland 'natural', or items 23s or 28s-f sho Examiner must be notified at once.	1600 Doral Dr.	20721	USA							
1 with 1 ms 23 be not be not		Vas Decedent of Hispanic Origin? ( Spe Yes, specify Cuban, Mexican, Puerto F		rican Indian, Black,						
r death with or items 23	1 Yes 2 No	- X								
urs afte tural" tural" amine	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decede	Yes 2 No specify:  ent's Usual Occupation (Give kind of wo	Specify: ork done 16b. Kind of Business	Asian						
136 thin 72 hours ne. than "natur edical Exam	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retire								
15-0036 filed within 72 hour Hygiene. d other than "natus the Medical Exames the Medical Exames Completed	17. Father's Name (First, Middle, Last)	N/A	N / A	A						
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Wilfredo C. Fulgueras									
, MD 21215-0036 and 2 should be filed within 72 eath and Mental Hygiene. tem 27 is marked other than " traumatic event, the Medical To Be Complet		ng Address (Street and Number or Ru Doral Dr. Mitchel								
nore, MD 2 gges 1 and 2 shou nt of Health and h tt: If item 27 is n other traumatt	20a. Method of Disposition  20b. Place of Disposition  Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or companies to the companies of the compani	osition (Name of cemetery,	Date 20c. Location - City o	r Town, State						
Baltimore, Pernit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 Other Specify: Metro Cr	5,2012 Baltimore	, MD							
Baltimo permit. Page Department o Important: injury or oth		Name and Address of Facility Beal	1 Funeral Home							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	512 NW Crain Hwy.	Bowie, MD 20715 respiratory arrest, shock, or heart	Approximate Interval						
/Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Hypertensive Atheros</b>	clerotic Cardiovas	scular Disease	Between Onset and Death						
Exammer	or condition resulting in death)  Due to (or as a consequence of):									
er	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			-						
ted Insit <b>Examiner</b>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-						
xecuted n and l-transit	d.									
ž g į	▼ UNPENDED									
D. Box 68760, the death certificate be earth certificate be earth of the attending physicial ched for use as the burial Physician/Medi	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1  Live birth   2  F	etal death 3 Ectopic pregnan	23d. Date of deliver Month	y Day Year						
lox 6 eath cer eath cer attendi for use	4 Pregnant at time of death 5									
O. B. It the de by the ached f	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?						
ires that the signed by 1 be detached by Pl			1 Yes 2 No 3 Pro	bably 4 🗸 Unknown						
Records, I The law requires ficate has been signage 2 should be Completed			24b. Were autopsy findings available prior to completion of cause of							
Recol The law icate has page 2 st			performed? death? 1 ✓ Yes 2 No 1 ✓ Y	es 2 No						
ita! Recition: The certificate rector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/Outpatient	26.Place of Death (Check or								
of Vit Physic er this eral dire	1 Ves 2 No Pospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of		Home 5 Residence 6 Othe  8d. Describe how injury occurred	r: Scene						
ion of vertending Pheeath.  the funeral the funeral ation: To	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No								
Division o spiral or Attending tours after death or and Director: After filled in by the func	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc. 2	8f. Location (Street and Number or Ru or Town, State)	ural Route Number, City						
Dospital hours willed	4 Homicide determined (Specify)  29a. Certifier									
Division of Vitz! Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.									
Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo							
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	October 31, 201	۷						
		W. Baltimore Street, Baltimo	re, MD 21223							
State	31. Date filed (Month, Day, Year)  32. Redistrar's Signature	all								

12-08221 Eileen Fox

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

2012 35951

neen rox		ment of health and Mental Hyglen licate of Death	Reg. No.							
Physician ledical Examine	1. Decedent's Name (First, Middle,Last)		of Death n Day Year ber 30, 2012 3. Time of Death 1526 hrs							
C. Sanda	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
Funeral	Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last I	Annapolis, Maryland birthday)   If Under 1 Year   If Under 24Hrs.   8. Date	Anne Arundel e of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Director	103–30–6162 <sub>1 M 2</sub> 73	Yrs. Months Days Hours Min. Max	rch 25, 1939 Country) New York							
any		wn or Location	10d. Inside City Limits							
Aaryland 28a-f show I at once	Maryland Anne Arundel 10e. Street and Number	Annapolis	1 XX Yes 2 No							
tifie		10f. Zip Code 21 401	10g. Citizen of What Country? U。S。A。							
or items 23	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? ( Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et								
s after d	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: White							
72 hour n "natu al Exap	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
5-0036 led within 72 hours Hygiene. other than "natu the Medical Exau	3 17. Father's Name (First, Middle, Last)	President & CEO  18.Mother's Name (First, M	Learning Center							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Christopher O'Connor	Margaret Nev	rille							
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Montal Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med	19a. Informant's Name/Relationship (Type, Print)  Jonathon R. Fenstermacher/spouse	19b. Mailing Address (Street and Number or Rural Rou 7 Southgate Avenue Annap								
re, N s 1 and 2 s 1 tand 2 f Health if item 2 cr trau		e of Disposition (Name of cemetery, Date natory or other place)	20c. Location - City or Town, State							
Baltimore, permit. Pages I ar Department of Hec Important: If ite	4 Donation 5 Other Specify:	timore Crematory 11/6/20	_ 1							
Baltin permit. Departm Importa	21. Signature of Funeral Service Licens	22. Name and Address of Facility John M. 147 Duke of Gloucester	St., Annapolis, MD 21401							
Physician	23a. Part I. Enter the disease, or complications that ceused the death. Do failure. List only one cause on each line <b>Gastrointest</b>	not enter the mode of dying, such as cardiac or respirational hemorrhage complicat	ing Approximate Interval Between Onset and							
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive At Due to (or as a consequence of):	herosclerotic Cardiovacsu	lar Disease							
	Sequentially list conditions, if any, leading to immediate									
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	(Disease or injury that initiated C.								
xecuted n and - transit	d d AMENDED 23a,pt.II,	,27,per me,g935 1-25-13 sm								
'60, ate be execut bhysician and re burial - tra	IF FEMALE: 23c. If yes, outcome of pregnance		23d. Date of delivery							
OX 6876(eath certificate at the trong phy for use as the treining phy	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death	4 Pregnant at time of death 5 Other (Specify)								
	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not result		Did tobacco use contribute to the cause of death?							
ires that the signed by doe detach	Chronic Alcoholica	1	Yes 2 No 3 Probably 4 ✔ Unknown							
of Vital Records, ag Physician: The law require. ther this certificate has been signered director, page 2 should be		24a	Was an autopsy findings available prior to completion of cause of							
L= - (			performed? Yes 2 No 1 ✓ Yes 2 No .							
of Vital ling Physician: After this certif funeral director,	1 Yes 2 No Inpatient 2 V ER	26.Place of Death (Check only one)  /Outpatient 3 DOA Other Nursing Home	5 Residence 6 Other:							
_ = . \4  Z	27 Manner of Dooth 29a Data of Injury 29b	b. Time of Injury 28c. Injury at Work? 28d. Des	scribe how injury occurred							
Division o spital or Attending nours after death. neral Director: After filled in by the fune Cortification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	, farm, street, factory, office building, etc. 28f. Loca	ation (Street and Number or Rural Route Number, City							
		<u></u>	own, State)							
Division  To the Hospital or Attent within 24 hours after death where Funeral Director: completely filled in by the	(Check only one)  Certifying Physician: To the best of my knowledge, cone)  Medical Examiner: On the basis of examination and/o and manner stated.	death occurred at the time, date and place, and due to the rinvestigation, in my opinion, death occurred at the time								
To with To con	29b. Signature and title of certifier	29c. License number O.C.M.E. USWE	29d. Date signed (Month, Day, Year)							
	30. Name and address of person who completed cause of death (Item 23a	u, D	October 31, 2012							
946	Theodore M. King, Jr., MD. Assistant Medical Exa.	miner 900 W. Baltimore Street, Baltimore	e, MD 21223							
Stat Registra		parle								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35952 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:00 Sarah Barbara Fenner ID 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbure Peninsula WICOMICO Regional Medical Center If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 218-34-8182 Director 73 1 □ M 2 🗷 F March 15,1939 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 230 Cherry Way 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Harvard Customs Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Glenmore James Bivens Mary Vertie White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Fenner/ Daughter 823 Sharp's Point Road - Fruitland, MD 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Missionary
Baptist Church Cenercy 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 / Donation 5 Other (Specify) 20, 2012 Princess Anne, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility <sup>22. Name and Address of Facility</sup> Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the board that the funeral director. that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav 24 hours after death.

• Funerel Director: After this certificate has been signed by the setely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ken 10-17-12 8.38 Am 15TC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

Maryland 21215-0036

Box 68760

P.0.

**Division of Vital** 

CAMUII

100 E 32 Registrar's Signatur

mund

Amended #4, 10/24/12, RML, St. Mary's County Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ 5:40p.m.<sup>M</sup> October Doris -- Loraine -- George Doris Lorane George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mary's Chesapeake Shores Nursing Center Lexington Park Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X**□ F Days Months Hours Month Day Year) 11/14/1925 Mississippi Director 86 421-22-0240 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Piney Point 10g. Citizen of What Country? 10f. Zip Code ò 10e. Street and Number Funeral items 23a United States 16099 Thomas Road 20674 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 X No "natural", or 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: Completed 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Secretary injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I- Important: If item 27 is marked of any injury or other traumatic even once. ၉ Naomi Williams Chester Evan Thrash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16099 Thomas Road, Piney Point, MD 20674 William A. George, Jr./Son 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 10/22/2012 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Strae Physician/ a ENd epps disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 5 Other (specify) ed by the a 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy eral Director: After this certificate I filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREAT MILLS ALL LEXINATION PIC. GIZABE H A. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ october 16<sup>ay</sup> 2012<sup>ar</sup> Roy Lee Griffin 6:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 54 Elder Place Charles Indian Head . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 1 🛛 M 2 □ F 217-68-9546 54 Nov. 3, 1957 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Charles Indian Head 1X Yes 2 ☐ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 54 Elder Place 20640 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. "natural", or itel Armed Force Black, White, etc. Never Married 2 Married Completed by and 2 should be filed within 72 hours after thealth and Mental Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examin Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes. Give 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Delivery Personal Supply Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roy C. Griffin Carol Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronge. Ronald C. Griffin Brother 122 Circle Ave., Indian Head, Md. 20640 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)Oct. Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Lic 22 Name and Address of Facility Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the shock, or heart fai he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or complications that Approximate List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ -IVee on cel disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialbeen signed by the attending physician should be detached for use as the buria Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Yes 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 Division of Vital filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Getachew Gebretsadik Medical 7:09 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5665 Thicket Lane Columbia Howard If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Min. Hours Director 213-47-3588 1**X** M 2 □ F 71 Oct. 29, 1940 Ethiopia r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD 1 Yes 2 X No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 3051 Shepperton Terrace 20904 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Yes 2X No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Colonial Parking Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Gebretsadik Woldeamanuel Getenesh Bedane . Page 1 and 2 should by ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Getachew/Son 20005 Spur Hill Drive, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Oct. 2<u>012</u> permit. Page 1 Department of Important: If it cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service License Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Hepatitis C Infection Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of n and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burget pages. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 <a>D</a> Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Day 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 Yes 2 No ☐ Yes 2 🛣 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Home 1 🗌 Yes 2 🖾 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titles 29c. License number 29d. Date signed (Month, Day, Year) D45471 Oct. 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #214

DHMH 17 Rev 06-2011

State

Registrar

Yeheyis Negussie, MD

1 8 2012

31. Date filed (Month, Day, Year)

Registrar's Signature

1111 Spring Street, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegisAMEND#8+19bperFH, 10/24/12; BWW, MbCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Daniel Garner Month 10 14 2012 1929p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George <u>Fort Washi</u>ngton Hospital Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day 12 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 161-32-0298 70 Pennsylvania **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c, City, Town or Lucation 10d. Inside City Limits rector Md Prince George 1 Xyes 2 No Oxon Hill ä 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20745 USA 4909 Wheeler Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 🗌 Widowed 4 🗎 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry DO NOT use retired)
Mechanic Elementary/Seconday (0-12) College (1-4 or 5+) \$elf Employed 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Garner Nancy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Adwing Code to Town, State, Zip Code 4909 - Wheller Rd Oxon Hill, Md 20745 4909 Wheller Rd Catherine Garner Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brentwood 4 ☐ Donation 5 ☐ Other (Specify) 10/22/12 Fort Lincoln Maryland 21. Signature of Funeral Service Licensee Shead Afuneral Home & Cremation 5732 Georgia Ave NW Washington, DC 20011 0777 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic 1000 disease or condition nknewn Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial nding physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UV MO DO0 5569 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) civingston Rd Ft. Washington 20144 Vanant 11711

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT

19 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 20, 2012 3:30 Рм Lee H. Gearhart Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Homewood at Crumland Farms Frederick 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. Feb. 12, Year 927 216-22-9225 85 Pennsylvania Director 1 🗆 M 2 🔀 F Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 11222 Alton Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force 1 ☐ Yes 2 ☒ No If Yes, Give Black White etc. <u>ک</u> 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) United States Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Cryptologist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph D. Hammond Mary Fulton Biggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Harbaugh / Daughter 11222 Alton Road, Frederick, Maryland 21701 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 23. permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 2012 Smithsburg, Maryland 21. Signature of Funeral Service Licensee Këehëy™ahd°Bastord PA Funeral Home M01473 106 E. Church Street, Frederick, Maryland 21701 Part 1. Enter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner STROK Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events anding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant Pregnant at time of death 5 Other (specify) Month Day Yea Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.
To the Funeral Director, After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ ✔o 24a Was an performed? Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Mursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 221936 MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4. ひかたしらの かり 65で でがれない FREDERICK MOZITOZ JOHNSON UR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar a RADAMA

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death Physician/ October 21, 2012 Goldman 5:00 Teuntje Emma p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 036-22-0343 Director 88 1 □ M 2 🕱 F March 25, 1924 Netherlands Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No MD Chevy Chase Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue, Rm. 1104 20815 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. Specify: White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Hem 27 is marked any injury or other traumatic and once. and Mental ೭ Gerritt Visser Emma Smit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Goldman/Son 28 Hathaway Road, Lutherville-Timonium, MD 21093 Date 23 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Oct. 23 2012 1 🔲 Burial 2 😾 Cremation 3 🗀 Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA Signature of Funeral Service Licensee Francis Address Collingins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypotension Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of as the burial-trapsit To the Hospital or Attending Physician: The law requires that the death certificate be executed Anasarca that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Cardiomyopathy, Atrial Fibrillation, Stage 3 Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? vithin 24 hours after death.

o the Funeral Director; After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2x No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10

Registrar

State

lmans

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brigit Schoellmann, MD

2 4

31. Date filed (N

D41752

1500 Forest Glen Road, Silver Spring, MD

Oct. 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 35960 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month 0 Physician/ PB P M Walter Gatling Medical 4c. County of Death Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Forest Glen Holy Cross Hospital 9. Birthplace (State or Foreign Country) Carolina North If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Month, Day, Year) 4/11/1936 243-52-9179 Director 76 1 XM 2 | F er then "neturel", or items 23e or 28e-f show the Medical Evanither must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Silver Spring 1X Yes 2 ☐ No MD Montgomerv 10e. Street and Number 10g. Citizen of What Country? Funeral 1909 Alabaster Drive within 72 hours after death with USA 20904 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Specify:Black ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 h end Mental Hyglene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4 or 5+) Private Supervisor Billing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Johnnie Gatling Maggie Lassiter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 end 2 shr Department of Health en Importent: If item 27 Is eny Injury or other treu once. Quinton Gatling 2325 15th Street NW Washington 20c. Location - City or Town, State arolina 20a. Method of Disposition 20b. Place of Disposition (Name of 10/2<sup>Date</sup>/2012 cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Jackson North Pineygrove Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kennedy St. NW Washington Dd Johnson & Jenkins Funeral Home 716 2001 21. Signature of Fundal Social Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe 10 set avidiDeath Immediate Cause (Final Asgstolic Cardiac Arrest Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 60 Min Examiner Cerebrovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: Examine signed by the ettending physicien end d be detached for use as the buriel-transit To the Hospital or Attending Physicien: The law requires thet the deeth carificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Essential Hypertension Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The continuing registroat. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D22309 10/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip Poth MD 8712 Maywood Ave. Silver Spring MD 20910 31. Date filed (Month, Day, Year) 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#16A per FH State of Maryland State Registrar 10/23/2012 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6825 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Anne Arundel Harwood If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) Davs Hours Min (Month, Day, Year) 217-12-3480 Director 1 X M 2 □ F 101 Yrs 01/25/1911 Wake, VA Usual Residence of Deced is then "netural", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Anne Arundel ShadySide 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4819 Atwell Road 20764 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Was Deceuding Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify: 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Deisel Mechanic (Specify only highest grade completed) al Hygiene. I other then " Elementary/Secondary (0-12) College (1-4 or 5+) USNA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit, Pege 1 end 2 should be file Department of Health end Mental I Important: If item 27 is marked of eny Injury or other traumatic end Mental F Thomas Joseph Groom Jessie Revere 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace C. Groom/Son 2458 Manakin Town Ferry Road Midlothian, VA 23115 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Decremation 3 Removal from State cemetery, crematory or other place, Atlantic Crematory 10/20/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): use as the burlel-transit Exam Hospitel or Attending Physicien: The law requires that the death certificate be executed ate hes been signed by the ettending physician and pege 2 should be detached for use as the burlel-trar Due to (or as a consequence of). resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 🗌 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Res 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending injury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funerei Medical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To ma best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 29b. Signature and titlers certifier 29d. Date signed (Month, Day, Year) 30. Name and address of pe npleted cause of death (Item 23a) (Type Print) EFENSE HWY 744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 23 2012 Registrar

DHMH 17 Rev 06-2011

Box 68760

P.0.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nancy Baker Gonder 2012 October 8:10 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Days (Month, Day, Year) Director 215-34-6305 1 M 2 X F Yrs 75 Apr 16, 1937 Maryland Usual Residence of Decedent or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 339 E Baltimore St 21787 USA filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "neturel", or 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) il Hygiene. I other then " Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Manufacturing 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Depertment of Heeith end Mental I Importent: If Item 27 Is marked o eny Injury or other treumetic eve once. Mildred Deberry Pege 1 and 2 should be Franklin Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Gonder, son 101 Springview Ct, Timonium, MD 21093 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/12/2012 Grace UCC Cemetery Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. SigNature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore Št, Taneytown, MD 21787 2a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY DISCASE ORRS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: physicien end the burial-transit Hospitel or Attending Physician: The lew requires that the deeth certificate be executed 24 hours efter death. Funeral Director: After this certificete hes been signed by the ettending physicien end that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregpant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ☐ Ectopic pregnancy Day Month 5 Other (specify) Pregnant at time of death After this certificate hes been signed by the infunerel director, page 2 should be deteched 9 | Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Gertifying Nurse Practitioner: It the best of my line wholey death occurred at the time, date and place, and due to the nause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, address of person who campleted cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Copyr Margaret Eileen Hetzer ,2012 1105 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Meritus Medical Center Washington Hagerstown 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 219-44-4352 Hours 69 Director 1 □ M 2 🔀 Jan. 21,1943 Nebraska Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13431 Little Antietam Dr. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta. Important: If item 27 is marked any injury over... ည Samuel J. Weston Francês Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Hetzer, Jr-husband 13431 Little Antietam Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 10-27-2012 Williamsport, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph. sician/ MONAR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in reclate cause. Enter Underlying Examiner Dust to (or as a consequence of): attending physician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death?
1 Yes 2 No certificate Yes 2 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending Investigation Accident npletely filled in by the 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - 22 -30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar -15aK.

JW-12

Tham

sistrar's Signature

Campus Rd

Stello Hagerstown MD21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ STEVEN OCTOSEP 19 3013 7:56 PM JAMES HARRISON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAGERSTOWN WKIHNGTON RERITUS MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** July 22,1955 Months Hours 220-58-4631 Maryland **Director** 57 1 X M 2 □ F Usual Residence of Decedent oms 23a or 28a-f show must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Washington Hagerstown 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1609 Woodlands Run 21742 U.S.A. items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. er than "natural", or ite the Medical Examiner Armed Forces? Black, White, etc. 1 XNever Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Yes. Give 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Interior Designer Furniture Co. other traumatic event. Department of Health and Mental H Important: If frem 27 is marked off any Injury or other traumatic averages. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Ellen Guessford Kenneth Leroy Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Stoops 1551 Violet Dr. Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-26-2012 | Hagerstown, MD Rest Haven Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician LEADING TU SIEPTIC SHOCK U AW HE MING disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 413145 SHILP C. DIFF COLOT Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 42175 burial-transit 11 HEEL ULCERATION GRADE that initiated events Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Hospital or Attending Physician: The law requires that the death certificate be each hours after death.

Funeral Director: After this certificate has been signed by the attending physicia Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LIVER TRUSPUNT RECIPIENT ON IMMUNE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of TYPE I DIABETES MELLURS ? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D74338 10/22 12012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID B. METZGER M.D TW-15 1116 MEDICA HAGERSTOWN MI)

Registrar

State

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ETHEL Day 2, 2012 Physician/ VERNA HENDERSON OCTOBER 9:13AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7020 COPPER LANE LAPLATA CHARLES Social Security Number 8. Date of Birth AUG Day Year If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 578-48-3511 88 Director 1 □ M 2 🔀 F CĂNĂDA 1924 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A WASHINGTON, D.C. N/A XXYes 2 No 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? 20008 Funeral 3930 CONNECTICUT AVE. NW UNITED STATES items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō þ XX Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗓 🛣 Specify Specify: WHITE 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " event, the Mer CANADIAN College (1-4 or 5+) YEARS Elementary/Secondary (0-12) ADMINISTRATIVE ASSISTANT EMBASSY 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည **JAMES** ETHEL CAMPBELL HENDERSON HENDERSON permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7020 COPPER LANE, LAPLATA, MD STEPHEN R. PEEL / NEPHEW altimore, Date 17, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCT. 2012 1 Burial 2XXCremation 3 Removal from State RIVERDALEY PARK RIVERDALE, MD 4 Donation 5 Other (Specify) CREMATORY TERRENCES L'EDUNSON FUNERAL SERVICE, 4433 WHITE PLAINS LANE, WHITE PLAINS. e of Funeral Service License Sign PA TERRENCE L. JOHNSON#M00993 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Schen" disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXInknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital NEPHEWS
5 Residence 6XXOther (Sp RESIDENCE) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death XX Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 aria D0050883 Oct. 12, 2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

Registrar's Signature

eonard town

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 11:30 PM Robert Ernest Hallahan October 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery . Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 053-26-9683 Months Days Director 1 X M 2 □ F 80 11/27/1931 New York Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "netural", or items 23a or 28e-f show traumetic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 Ty Yes 2 No 10f. Zip Code 20003 10e. Street and Number 10g. Citizen of What Country? Funeral 213 4th Street SE United States . Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1953— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. <u>გ</u> 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed Specify: White 3 Widowed 4 Divorced 1955 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Broadcasting Public Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Donald Hallahan Louise Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 4th Street SE Washington, DC 20003 Health tem 27 Marlet Benedick/ Friend permit, Page 1 and 2 Department of Health Important: If item 27 eny injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA National Crematory 10/18/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons LLC. M00063 5130 Wisconsin Avenue NW Washington, DC 20016 23a. Part 1. Enter the disease, or come lightions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute Anemia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and is the burial-transit The law requires that the death certificate be executed Severe Peripheral Vascular Disease Years that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death been signed by the servould be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: of Vital director 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number aua2 10-15-12 D50987

DHMH 17 Rev 06-2011

State

Registrar

1500 forest

Glen and Silver Spring mD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Registrar's Signature

NAWAZ

1 8 2012

AHMED

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 17:58 M Medical tible 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4b. 4c. County of Death 9. Birthplace (State or Foreign Country)
Nyack, NY Social Security Number 7. Age In yrs. last birthday) If Under 1 Year I' If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 217-72-1108 Director 1 □ M 2 🔀 F 56 ebruary 9,1956 and Mentel Hygiene. end Mentel Hygiene. Is marked other than "natural", or Items 23a or 28a-f show reumetic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Merylend Directo Silver Spring 1 Yes 2 XNo Md. Montgomery 10f. Zip Code 20904 10e. Street and Number 10g. Citizen of What Country? Funera 517 Highgate Terrace 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White 14. Race - American Indian, 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retiged).
Supervisor of Health&Phys. Ed. (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Be other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pege 1 and 2 should be.
Department of Health and Mentel Important: If item 27 is many injury or other. ၉ Harkaway William Werlin Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara 11410 Strand Dr. #410, Rockville, Md. 20852 Harkaway / mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Judean Memorial Garden Oct. 22,2012 Olney, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility | Orchinsky Hebrew Funeral Home 21. Signeture of Funeral Service Licensee 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Acute myeloid leutemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires thet the death certificete be executed Due to (or as a consequence of): resulting in death) Last burielsigned by the ettending physicien Id be detached for use es the burie Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 plonths? Day 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccq use contribute to the cause of death? by cete hes been sig Completed 1 Yes No. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funerel Director: After this certificate the properties of the funerel director, page 2 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No ☑ Natural 5 Pending injury 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tha Hospitai Medical 29a. Certifier 1 📑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fittle of ce 29d. Date signed (Month, Day, Year) 000 30. Name and address person who completed cause of death (Item 23a) (Type, Print) ther Pa 800 Drieans Street

State

Registrar

31. Date filed (Month, Day, Year)

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 10:23 10 Elizabeth Hawkins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges <u> Prince Georges Community Hospital</u> <u>Hyattsville</u> 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F Months Days Min. Hours (Month, Day, Year) 05/15/1935 South Carolina Director 247-60-6146 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 USA 5504 Eads Street. NE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene.

is marked other than "natural", If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Specify: Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Assistant Educational 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Cannell Griffin Weslev Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Mary Ann Hawkins-Daughter 726 49th Place, NE Washington, DC 20019 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) MD Nat'l Mem. Park 10/20/2012 Laurel, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Inter the disease, or compercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Fa Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consiquence of) Exami attending physician and for use as the bunal-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 No P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖳 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 74371 450 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE ROACH 3201 Registrar's Signa 31. Date filed (M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35969 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 25,2012 Year 9:25a.mM October Charles Phillip Howard Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice House of St. Mary's Social Security Number | 6. Sex | 17. Age ( St. Mary's Callaway 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Davs Hours Director 577-14-5544 1X M 2 □ F 05/26/1920 Washington, DC 92 Usual Residence of Decedent permit. Pege 1 end 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "nature!", or items 23a or 28e-f ehov enty injury or other treumatic event, the Madical Examiner must be notified #1 ence. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Director 1 Yes 2 No Tall Timbers Mary's Marvland St. 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral United States 20690 44472 Finnacom Road 12. Was Decedent Ever in U.S. Armed Forces?

17 Yes 2 No
1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ♥ Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Heating and Plumbing Mechanical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Agnes Doyle William George Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11312 Wollaston Circle, Issue, MD 20645 Mike Howard/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date IX Burial 2 ☐ Cremation 3 ☐ Removal from State George Cath. Cem. 11/02/2012 Valley Lee, MD 4 Donation 5 Other (Specify) 21. Signature of Educal Service Libensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) estallitation Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physicien: The law requires that the death certificete be executed signed by the ettending physicien end d be detached for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed cate has been sly pege 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No After this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ᅙ 2 (XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, à determined within 24 hours efter To the Funerel Direc completely filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 🗍 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖵 Certifying Nurse Practitionen To the best of my knowledge, death upcurred at the time, date and place, and due to the causals) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 06-2011

RYNL

State

10 H

30. Name and address of pl

Jennifer &chm 31. Date filed (Month, Lay, Year)

&chmidt,

OCT 3 1

40900 Merchants Lane, Suite 205, Leonardtown, MD 20650

son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:51 PM October 28, 2012 William Douglas Hobgood Medical 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** St. Mary's **Mechanicsville** 41695 New Market Turner Road Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, **Funeral** Min. Months Hours Director 237-54-5133 78 Yrs North Carolina 09/02/1934 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State death with the Maryland Director 1 🗌 Yes 2 🗷 No Mechanicsville Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 items 23a or ner must be r Funeral USA 20659 41695 New Market Turner Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n rmed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed r than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other th any injury or other traumatic event, the the United States Navy Master Chief 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eva Wade Alpheus Hobgood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41695 New Market Turner Road Mechanicsville,MD 20659 Marian E. Hobgood/ Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State Charles Memorial Grds 11/01/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Pature of Funeral Service Licens 22. Name and Address of Facility

Mattingley—Gardiner Funeral Home P.A.

41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MANTLE CELL CYMPHONA Jon-Hodckin Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day for 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No the 9 Unknown signed by t Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed Yes 2 certificate has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide determined 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, MJ lo 2012

State

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Mor

Amir M. Khan, MD 25500 Point Lookout Road Leonardtown, MD

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT **3 1** 2012

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17:30 Thelma Louise Hall October 0 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Months Hours Director 217-32-2824 1 M 2 K F Yrs 78 Usual Residence of Deceder 03/15/1934 Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 2 should be filed within 72 hours after death with the Maryland Hith and Mental Hygiene.
27 is marked other than "naturar", or items 23a or 28a-f shor traumatic event, the Medical Excenteer must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No <u>Maryland</u> St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20621 USA 38100 Frank Hall Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give þ timore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 👿 Widowed 4 🗌 Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dry Cleaning Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Grace Irene Lacey James Carroll Quade, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau once. 38100 Frank Hall Lane Chaptico, MD James G. Hall/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 11/3/2012 Bushwood, MD Signature of Funeral Service Licens 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease of liquit) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred usk 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

RMe State

Jennifer Ma Schmidt 40900 Merchants Lane, #205 Leonardtown, MD 31. Date filed (Month, Day, Year) 31

30. Name and address of pegs

Registrar's Signature

on why completed cause of death (Item 23a) (Type, Print)

Registrar

2

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 5:00 P. Claudia Laverne Harris Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 578-64-2288 64 **Director** 1 □ M 2 🛣 F 01/09/1948 Wash.,D.C. Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State Director notified 28a-f 1x Yes 2 No Md. P.G. Landover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be r Funeral 7011 E. Chesapeake Street 20785 U.S.A. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ō þ 1 XNever Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Black 'natural", 3 Widowed 4 Divorced Completed er than "natur , the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care Ith and Mental Hygier 27 is marked other to traumatic event, the years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Lee Etta Cross Otis Lee Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rubin W. Harris/Brother t: If item 27 i 6408 Tasajillo Trail, Austin, Texas 78739 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 10/25/12 Lincoln Cem. Brentwood, Maryland Signature of Funeral Service Licens Sons Co. Inc. Washington, D.C. 20019 nach Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death be detached for use 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes No Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 s 1 Yes 2 No director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 🔼 Inpatient 2 🗆 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of De 28b. Time of 28c. Injury at work? Natural ZAccident 5 Pending s after death. 1  $\square$  Yes 2 🗌 No the Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date sign 55M

Registrar DHMH 17 Rev 06-2011

State

31. Date fi

67 Busto

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Caridad V. Hebert 7:00AM October 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kris Leigh Assisted Living Davidsonville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs, last birthday) **Funeral** 89 **Director** 216-74-2080 1 □ M 2 🛛 F 3/5/1923 Philippines Il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 ☐ Yes 2 🕅 No Prince George's Maryland Upper Marlboro 10g. Citizen of What Country? Funeral 20774 USA 17817 Central Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:Asian Pacific 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ministry Of Foreign Elementary/Secondary (0-12) College (1-4 or 5+) Affairs Diplomatic Attache Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 end 2 should he filed ent of Health end Mental H nt: If item 27 is marked ot y or other traul atic even မ Vera-Cruz Asuncion Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Hebert/Husband 17817 Central Avenue, Upper Marlboro, MD 20774 20a. Method of Disposition
1 ☐ Burial 2 🌡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit, Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) Kalas Crematory 10/20/2012 | Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signatur // Fu ral S ice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home nliller 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MACHINE D BLEGD o de disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ZWE RICK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and al-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy
performed After this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 'thin 24 hours after death.' the Funeral Director: After this certificampletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Spe Assisted Livin 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 1 5 Pending 1 🗆 Yes 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fi 29a. Certifier 2 ☐ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature dittle of certifier 29d. Date signed (Month, Day, Year) 130718 16 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAZKESUN LED, 2003

DHMH 17 Rev 06-2011

Registrar

State

31. Date filed (Month, Day, Year)

OCT 18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35974 State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aneita Rebecca Heron October P M 9:15 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
April 8. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. g. Birthplace (State or Foreign **Funeral** 366-56-8145 1 □ M 2 😿 F 74 Director 1938 Jamaica Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Boyds 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14241 Kings Crossing Blvd. 20841 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2000 Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", Black 3 ₩ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Aide 12 Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Coghiel Sissy (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Roy Ward/son 14241 Kings Crossing Blvd, #111 Boyds, MD 20841 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/19/2012 | Baltimore, Maryland Signature of Juneral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerotic Cardiovascular disease Physician/ disease or condition resulting in death) unknown Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent precolant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 by Kidney dialysis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D43121 howd 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHOWDHURY, MD; 605 Main Street, Laurel, MD20707 NURUL 31. Date filed (Month, Day, Year) OCT 18 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:13 am N. Hebert 201 Melvin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Coasta 15 ttosni 60 WIROMIZO 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Director 435-22-5352 1 X M 2 🗆 F Louisiana 11-24-1921 90 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No Salisbury Wicomico MD 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a USA 21804 403 Valleywood Drive items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Types 2 No 1942-Yes, Give 14 Bace - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White Completed 3 X Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 12 Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Basque Sylvia Hebert Oliphiade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8404 Whippoorwill Drive, Ft. Worth, Texas 76123 Raymond J. Hebert - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, X Burial 2 Cremation 3 Removal from State Springhill Memory Gd. 10-26-2012 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bounds Funeral Home 21. Signature of Funeral Service 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Eetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Onknown 1 Yes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 2010 1 Yes & 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Certificate: To Be Hospital Other: Haspure 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 6~2 lake 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10/20/12 1063199

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

23 2012

Herbert, Melvin

SHORE DR.

SALISBURY

address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN

32. Registrar's Signature

VOHRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 John C. Hayes 9:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City Lighthouse Senior Living Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Director 218-28-1503 15 M 2 | F 84 June 2, 1928 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Windsor Mill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8316 Lages Lane 21244 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes No If Yes, Give Year or Dates. Black, White, etc. 2 1 Never Married 3 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ifilad within 72 tal Hygiane. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mechanic Automobile Department of Health end Mantal Hy Important: If item 27 is marked other any injury or other transment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Pauline Lambros Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3002 Rices Lane Windsor Mill, Maryland 21244 Fayette J. Hayes/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greek Orthodox Ceme. 10/25/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications at a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mentig Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): siclan and burial-transit Exami The law requires that the death cartificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending physic d for use as the b IF FEMALE: signed by the attendin I ba datached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 autopsy this cartificate Yes 2 N 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Sp. Assitul Living 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No to Hospital or Attending P n 24 hours after death.
Funaral Director: After the leatally filled in by the funeral Certificate: 28d. Describe how injury occurred After t injury Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funal complataly fi 29a, Certifier only one) 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6334 CEDAR W #103 COLUMBIA. ANDREW LAZRIS. MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

68760

Box (

P.O.

of Vital

Division

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or								_		_	jible.		
		For State		State	of Mary	land /		artment <i>tificate</i>			and N	/lental Hy		0	0.1	0 0	C07
		Registrar  1. Decedent's Name	e (First, Middle	, Last)			Cei	uncate	OI D	eatri		2. Date of De	Reg. I	No.	<u> </u>	3, Time (	of Death
Physicia Medic													R 1	8, 20	)12		35 Р м
Examin													$\overline{}$	4c. County	of Deat	h	
		412 RON 5. Social Security Nu			7 4 //-	t4 b	1-41-4-1	ST:		ISVIL If Under				QUE		NNE'S	
Funeral Director		133-28-88		6. Sex 1 <b>X</b> M 2 □ F	7. Age (In y	yrs. Iast bi 75	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, Da	ay, Year		Cot	hplace (State untry)	or Foreign
, MC		Usual Residence of	of Decedent											VORK			
ryland I-f sho ied at	ctor	10a. State	10b. County		10c	:. City, To				_						10d. Inside (	City Limits es 2X No
or 28a	Dire	MARYLAND  10e. Street and Num		IN ANNE'S			STE	10f. Zip C		<u> </u>			100	Citizen of \	What Co		:5 ZA_ 140
with the same same same same same same same sam	Funeral Director	412 ROMA	NCOKE 1	ROAD						666				NITEL		-	
death items ser m	핊	11. Marital Status		12. Was Dec Armed Fo		n U.S.	13. V								e - Amer	rican Indian,	
after all", or xamir	Completed by	1 Never Marri		ied 1 <b>K</b> Yes If Yes, Gi	ive 2 No 1	.956		☐ Yes 2				, ,			Specify: WHITE		
hours natura ical E			15. Deceden	Year or D		.958	Sa. Deced	cedent's Usual Occupation						Kind of B	usiness/	Industry	
iin 72 ie. han "ı	g	Elementary/Seco		st grade completed College (	1-4 or 5+)		Ìife. D	kind of work O NOT use r	etired)		t of worki	ing	_				
d with tygier ther t	Be C	12 17. Father's Name (F	First Middle I	4			P.	ARKS I	IRE			· · · · · · · · · · · · · · · · · · ·		ARKS		VICE	
be file ental F ked o c eve	힏			#SI)								e (First, Middle V MFAT.II		en Surname	<del>?</del> )		
hould and Mi s mar umati		LEON HATHWAY  MARION MEALUS  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street and Number or Rural Route Number, City or Town, Street Rural Rout										State, Zip	Code)				
nd 2 st ealth a m 27 ii	- !	KEITH HA	ATHWAY/	SON		4	1 WI	LSON	ROAI	o, ox	FORD	, CONN	ECTI	CUT	0647	8	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ĺ	20a. Method of Disp		3 Removal fron	n State	)b. Place ceme	of Dispo	sition (Name	of er place	e)	OCT.	Date 24.	20c.	Location -	City or	Town, State	
it. Pag rtmen rtant: njury	į	4 Donation	5 Other (S	pecify)	C	<u>:ОММÜ</u>		SVILLE CEME								, NEW	
Depa Impo any i		21. Signature of Fur	Service L	.censee	al		<sup>22</sup> F	ELLOW	Address S, F	HELFE	NBEI	N & NEW	WNAN	1 FUN	ERAL	HOME,	P.A.
TENE		23a. Part 1. Enter the		complications that	nob line		not ente	r the mode	of dying	g, such as	cardiac c	or respiratory a		HAKT	LAND	Approxima	ate
Physician/		Immediate Cause (I	Final	Thy one cause on e	ME-	7A.5	7071	t 60	INO	- (	ANC	AC				Interval Be Onset and	
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  ME7A 57A71T CUNG CANCIAL  Due to (or as a consequence of):															
	Jer	Sequentially list cor if any, leading to im	nditions,	b. Due to	(or as a con:	sequence	e of):								-		
d ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events															
6 = 2	al Ex	resulting in death) L		Due to	(or as a con	sequence	e of):										
is that the death certificate be ex- gred by the attending physician be detached for use as the buria	<u>ğ</u>		10	d													
certific nding use as	by Physician/Medic	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, ou	itcome of pre	egnancy	-	23(						23d. Da	3d. Date of delivery		
death e atte	sicia	in the past 12 r	months?		e Birth 2 🗀 gnant at time			Li Ectopic pregnancy							Year		
at the	P Š	9 Unknown Part II. Other signifi	icant conditio			t resulting	a in the u	nderlying ca	use dive	en in Part		02 - Did	tabaaa		ibuta ta	the cause of	Joseph ?
res tha	ا م	, are in water organic	,5411.54114.45	commoding to t	20411 541110	r roodining	9 117 1110 0	ndonying od	doo giri	0171177 (010	••			2 No	\/	obably 4	
been shoul	Completed											24a. Was	an	24b. <sup>1</sup>	Were aut	opsy findings	available
he law te has age 2	gmo											auto	ormed2	1	prior to d death?	completion of	cause of
ian: Ti rtifical ctor, p	Be C	25. Was case referre	ed to medical						26. Pla	ice of Dea	ith (Check	1 🗌 Yes conly one)	2	No	I 🗀 Yes	2 No	
hysic this ce al dire	욘	1 🗆 Yes 2 🕽	No		Inpatient 2			t 3 🗆 DOA	Other	r: 4 🗌 N	ursing Ho	me 5 Resi	idence	6 🗆 Othe	er (Speci	fy)	
ding F h. After 1 funera	ate:	27. Manner of Death 1 Natural	5 Pending	9	e of injury nth, Day, Yea		. Time of injury	M 280	work?			28d. Describe	how inj	ury occurr	ed		
Atten r deat ector: by the	Certificate:	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Investig 6  Could r determi	not be 28e. Place	e of Injury - A		farm, stre			163 2	$\rightarrow$	28f. Location (			er or Rur	al Route Num	nber,
ital or irs afte al Dire				build	ling, etc. (Sp	ecity)						City or To	wn, Sta	ite)			
To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Medical		Medical E	Physician: To the I xaminer: On the ba	asis of examin	nation and	/or invest	igation, in my	y opinior	n, death o	ccurred at	the time, date	and pla	ce, and du	e to the c	ause(s) and m	anner stated.
Fo the complex	Σ	only one) 3 29b. Signature and t		Nurse Practitione		of my kn	nowledge,	200.1	icense	number			204 F	lata alana	d Manth	Day Voorl	
			( XX	1 ~	na D.				D	1648	52			10/1	9/12	?	
1UTINS		30. Name and addre			se of death (	Item 23a	(Type, P	rint)	00:3	M	dica	Park Cologn	wer	1 Su	ile2	-10,	N a s s
		31. Date filed (Month	4	ZAVIN 32A	Registrar's Si	HI/ G		HNI	~4/	10115	61	LOLOGY	1	Hr	Jan 1	ilis M	1) 2140
State	*	00	h Day, Year)	1117 2	rogiotiai 5 01	griatule 6	,										

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-08065 State of Maryland / Department of Health and Mental Hygiene Sydney Hitchcock 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1629 hrs October 24, 2012 Medical Examiner Sydney Elise Hitchcock 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Talbot **Faston** Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign North Cou(Ma)rolina Months Days Hours Director 864-60-1456 Dec. 12,2011 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Denton MD Caroline it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.

relact: If item 27 is marked other than "matural?, or items 23a or 28a-f she y or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21629 1204 Trice Meadows Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 X Never Married Yes white 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify 3 Widowed 含 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) did not work Baltimore, MD 21215-0036 none 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Greg Hitchcock Sherri Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Greg Hitchcock father 1204 Trice Meadows Circle, Denton, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Crematory of Delmarva 10/26/12 Delmar, DE 4 Donation 5 Other Specify: 22. Name and Address of Facility Thomas Funeral Home P.A. eture of Funeral Service Licensee 700 Locust St., Cambridge, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death aSudden Unexplained Death In Infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Examiner Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

\*Runeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be deached for use as the burial - transi Physician/Medical AMENDED 23a, 27, 28a-f, per me, g935 1-9-13 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown has been signed by the 2 should be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed death? ✓ Yes 2 No 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural 1 Yes 2 X No unknown Pending fd 10-24-12 |fd 3:21 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1107 Weeping Hollow 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide determined (Specify) Fd: At Daycare Center Denton, MD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

within 2 To the

> 900 W. Baltimore Street, Baltimore, MD 21223 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

October 25, 2012

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

State Registrar

29b. Signature and title of certifier

gr

			1 _ State	partment of Health and Nertificate of Death	/lental Hygie Reg.	2012 34	598							
	_		Registrar  1. Decedent's Name (First, Middle, Last)	Timodic of Bodin	2. Date of Death	3. Time								
В	Physici		Ethel Hinegardner			Day 2012 6:45	АМ							
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
-	LAUTH		Long View Nursing Home	Manchester		Carroll County								
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 XF 82 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 6, 19	9. Birthplace (State Country) Kansas	or Foreigr							
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	cention		10d. Inside	City Limits							
	arylar shov	'n	10a. State   10b. County   10c. City, Town or I   Maryland   Baltimore County   Hampstea				s 2X No							
	the M 28a-f otifie	Director	10e. Street and Number	10f. Zip Code	10a.	Citizen of What Country?								
	with yard	ق	18412 Gunpowder Road	21074	"	nited States								
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White								
5-0	72 ho	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work	ding 16t	. Kind of Business/Industry								
12	ithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work . DO NOT use retired) <b>emaker</b>	3	own home								
2	iled w Hygie Iher t	ပ္ပ	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai									
Maryland	d be f ental ced or	Be c	Canie Lawson Hollins	Lila Re		,								
2	should nd Me mark	2	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, Zip Code)								
	nd 2 alth a 27 is		Patricia G. Hinegardner/daughter 1	8412 Gunpowder Road	d Hampste	ead, MD 21074								
Baltimore,	Pages 1 and of He int: If item			ematory or other place)	. 20.	. Location - City or Town, State	and							
Balti	permit. Departr Imports any Inji				line Funer	al Home tead, Maryland	2107							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
many.	Physician		Immediate Cause (Final disease or condition	Serile dema	infla	Onset an								
ا	/Medical		resulting in death)  a.  Due to (or as a consequence of):			1								
	Examiner	L	Sequentially list conditions. b											
	ted sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	be executed sician and burial-transit	dical Examiner	that initiated events resulting in death) Last  C											
8760,	sician buria	ia E												
687	fficate   g physics the k	edic	d											
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me		B ☐ Ectopic pregnancy Dother (specify)		23d. Date of delivery Month Day	Year							
σ.	w requires that the dispense that the dispension of the should be detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of	of death?							
rds	juires n sigr Ild be	d by			1 ☐ Yes	2 No 3 Probably 4 [	Unknowr							
Division of Vital Records,	sician: The law rec certificate has bee rector, page 2 shou	Completed			24a. Was an autopsy performe		gs available of cause of							
ta	an: T tificat tor, pa	Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one)	No 1 □Yes 2 □No								
	Physici this cer al direc		examiner?  1  Yes 2  Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other:	ome 5 Residence	e 6 ☐ Other (Specify)								
0	ding Ph n. After th funeral	J:uc	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) 28b. Time Injury (Month, Day, Year)		28d. Describe how	injury occurred								
Sio	eath. or: A the fu	catic	2 Accident investigation	M 1 □Yes 2 □No										
Divi	I or Attending Physician: after death. Director: After this certifica d in by the funeral director, p	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route N State)	umber,							
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier  (Check only one)  TDecrtifying Physician: To the best of my knowledge, de a control of the control of the pasis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as stated. and place, and due to the caus	e(s)							
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year	)							
	1			D37573	'	Detaber 15, 7	2012							
	10 PC		30. Name and address of person who completed cause of death (Item 23a) (Type Screen ND NO	e, Print) Box 7613	salis bu	Detaber 15, 3	محر							
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 6 2012	Box 7613 :										
		2	UUI & V LUIG IMERICAN ST.	No comment										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	= For AMEND#23a(a+bpenyn), 10/31/12; BWW, 10/31/12; BWW, McC	b Certi	ificate of De	eath		Reg. No. 20	12 35981
	Physicia Medic		Decedent's Name (First, Middle, Last)     MICHAEL SPENCER JACKSON				2. Date of Dea		3. Time of Death 10:40 PM
	Examin		4a. Facility Name (if not institution, give street and number)  Laurel Regional Hospital		4b. City, Town, or Lo	urel		4c. County of E	e George's
	Funeral Director		5. Social Security Number 276-64-6239 6. Sex 1 IX M 2 $\square$ F 56			f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 1/19/1	, Year)	Birthplace (State or Foreign Country) everly, Md.
	aryland a-f show fied at	Director	10a. State 10b. County 10c. C	ity, Town or Loca .aure1	ition				10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	with the Ma 23a or 28 ust be noti	Funeral Dire	10e. Street and Number 3593 Whiskey Bottom Rd.		10f. Zip Code 20724			10g. Citizen of What	t Country?
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ★★Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates.	If Y	as Decedent of Hisp yes, specify Cuban, Yes 2 X No	Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, /hite, etc. olack
Baltimore, Maryland 21215-0036	within 72 houn giene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	on ing most of worki	ing		Kind of Business/Industry		
land	ld be filed wental Hyg arked oth atic event	To Be	17. Father's Name (First, Middle, Last)  Maurice E. Jackson Sr.		1	8. Mother's Name	e (First, Middle, Willi	Maiden Surname) i ams	
Mary	12 should lith and Me 27 is mark		19a. Informant's Name/Relationship (Type, Print) Maurice E. Jackson Jr./brother					r, City or Town, State	
nore,	Page 1 and ment of Heal ant; If item 3 ury or other		1XXBurial 2 Cremation 3 Removal from State		tion (Name of atory or other place) In Cemete		Date 2 / 1 2	20c. Location - City	
Baltir	permit. Pag Department Important; any injury o		21. Signature of Funeral Solice Licensee	22. 1	Name and Address	of Facility Uni	iversal		
minute.	Physician/			ocardia <i>men</i> ar	the mode of dying, al Infa ////	such as cardiac c rct	or respiratory arr	rest,	Approximate Interval Between Onset and Death Unknown
1	Medical		resulting in death)  Due to (or as a consecutive death)	quence of):	1				
	Examiner	ı.	Sequentially list conditions, b.		arct				Unknown
		Examiner	Sequentially list conditions, if any, leading to his mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consection)	Clience off:	arct				UnKnowin
092	ate be executed physician and the burial-transit	edical Examiner	sequentially list conditions, for the form and the cause. Enter Underlying Cause (Disease or injury that initiated events control of the conditions of the c	Clience off:	aret				Unknowin
Box 68760	ate be executed physician and the burial-transit	edical	sequentially list conditions, for the form and the cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence of):				23d. Date o Month	f delivery Day Year
Box 68	ate be executed physician and the burial-transit	by Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown	quence of):  nancy stal death 3     f death 5	Ectopic pregnancy Other (specify)	n în Part I.		Month	
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	quence of):  nancy stal death 3     f death 5	Ectopic pregnancy Other (specify)	n in Part I.	1 🗆 24a. Was	Month  bbacco use contribut  Yes 2 No 3 [  an 24b. Wern  prior  grand deal	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available r to completion of cause of
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Be Completed by Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Vinknown	quence of):  nancy stal death 3   f death 5   esulting in the unc	Ectopic pregnancy Other (specify) derlying cause giver	e of Death <i>(Chec</i>	1	Month  bbacco use contribut  Yes 2 No 3 [  an 24b. Wern  prior  deat  2 No 1 [	Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   2   1   2   2   2   2   2   2   2	quence of):  nancy stal death 3   f death 5   esulting in the unc	Ectopic pregnancy Other (specify)  derlying cause giver  26. Plac 3 □ DOA Other:  28c. Injury a work?	e of Death <i>(Chec</i> e 4	1 24a. Was autor performence only one)	Month  bbacco use contribut  Yes 2 No 3 [  an 24b. Wern  prior  grand deal	Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No
Division of Vital Records, P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   2   1   2   1   2   1   2   1   2   1   2   2	quence of):  nancy stal death 3   f death 5   esulting in the und  28b. Time of injury  home, farm, stree	Ectopic pregnancy Other (specify)  derlying cause giver  26. Plac 3 □ DOA Other: 28c. Injury a work? M 1 □ Ye et, factory, office	e of Death <i>(Chec.</i> 4  Nursing Ho  t  s 2  No	24a. Was autor period 1  Yes k only one)  me 5  Resid 28d. Describe h  28f. Location (\$ City or Tow	Month  bbacco use contribut  Yes 2 No 3 [  an 24b. Wern  prior  deat  2 No 1   dence 6 Other (S  now injury occurred  Street and Number of   In, State)	Day Year  te to the cause of death?  Probably 4 Unknown e autopsy findings available to completion of cause of th? Yes 2 No  Specify)  Property No
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months?   1	quence of):  nancy stal death 3     f death 5      ER/Outpatient 28b. Time of Injury  home, farm, stree ify)	Ectopic pregnancy Other (specify)  derlying cause giver  26. Plac 3 □ DOA Other: 28c. Injury a work? 1 □ Ye est, factory, office	e of Death (Chec.  4  Nursing Houte and Nursing Houte and place, a death occurred a	24a. Was autop performence of the control of the co	Month  bbacco use contribut  Yes 2 No 3 [  an	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available r to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number,  as stated. the cause(s) and manner stated.
Box 68	ate be executed bhysician and the burial-transit	Certificate: To Be Completed by Physician/Medical	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 12 months?   1   Live Birth 2   Femanta in the past 13 months in the past 14 months?   25. Was case referred to medical examiner?   1   Ves 2   No   25. Was case referred to medical examiner?   28a. Date of injury (Month, Day, Year)   28b. Place of Injury - Attack in the past 14 months in the past 15   Pending   28b. Place of Injury - Attack in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On the basis of examination in the past 15   Medical Examiner: On	quence of):  nancy stal death 3     f death 5      ER/Outpatient 28b. Time of Injury  home, farm, stree ify)	Ectopic pregnancy Other (specify)  derlying cause giver  26. Plac 3 □ DOA Other: 28c. Injury a work? 1 □ Ye est, factory, office	e of Death (Chec.  4  Nursing House State and place, a death occurred a time, date and plaumber	24a. Was autop performence of the control of the co	Month  bbacco use contribut  Yes 2 No 3 [  an	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available r to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number,  as stated. the cause(s) and manner stated. her as stated.
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   2   1   2   2   2   2   2   2   2	quence of):  nancy stal death 3   f death 5   esulting in the und  28b. Time of injury  home, farm, stree ify)  wledge, death oc ion and/or investig f my knowledge, c	Ectopic pregnancy Other (specify)  derlying cause giver  26. Plac 3 □ DOA Other: 28c. Injury a work? M 1 □ Ye et, factory, office  courred at the time, of pation, in my opinion, death occurred at the 29c. License n  29c. License n  27 2	e of Death (Chec.  4 Nursing Hotel the set of No  date and place, a death occurred a time, date and place time, date and place.	24a. Was autop performence of the control of the co	Month  bbacco use contributives  Yes 2 No 3 [  an	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available r to completion of cause of th? Yes 2 No  Specify)  r Rural Route Number,  as stated. the cause(s) and manner stated. her as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			Tiviary			rtmeni <i>ificate</i>			and IV	rientai Hy	gien Reg. N	21	112	35982
	Physicia Medic		Decedent's Name (First, Name IRENIA IRENIA)		,								2. Date of De Month		<del>0</del> /201	<b>Ž</b> ear	3. Time of Death 10:26 PM
-	Examin		4a. Facility Name (if not insti 13415 Duchin	_	street and num	ber)			4b. City, T			of Death		4c. County of Montg			Y
	Funeral Director		5. Social Security Number 220–42–0407		ex □ M 2 <b>X</b> F		rs. last birthd		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 8/29/]	ay, Year,		9. Birthp Count MD	lace (State or Foreign ry)
	and show dat	tor	Usual Residence of Deced  10a. State  10b. Co				City, Town o	or Loca	ation			·	-,, -			10	Od. Inside City Limits
	e Mary r 28a-f notifie	Director	MD Mor	ntgam	ery	Ge	ermant	.own									1 X Yes 2 No
	n with th	Funeral I	13415 Duchin	Road					10f. Zip (				USA			What Country?	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	urs after death ural", or item il Examiner n	by	11. Marital Status  1 Never Married 2 3  3 Widowed 4 Divi		12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 No	lo.			as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F Yes 2 No Specify:			cify Yes or No- Rican, etc.)			Race - American Indian, Black, White, etc. Sify: Black	
15-(	72 hou an "nat	Completed	(Specify only		de completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)						Kind of Bu	siness/Ind	ustry		
212	d within ygiene. her tha nt, the I	Be Co	Elementary/Secondary (0 12th		College (1-	4 or 5+)			n Services-DOD				Gover			nment	
Maryland	d be filed fental H rked ot tic ever	To B	17. Father's Name (First, Mid Chester Hamme								e (First, Middle, ewart	Maidei	n Surname	)			
Mary	should h and M 7 is ma trauma		19a. Informant's Name/Rela		, ,	- 1	Mailing Address (Street and Number or Re									ode)	
re,	1 and 2 of Healt item 2 other 1		Andrew Jones, 20a. Method of Disposition		_	201	o. Place of D	)isposit	tion (Name	e of	T		mantown Date		2087 Location -		vn, State
Baltimore,	t. Page tment c rtant: If njury or		1 XBurial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot	her (Specif	/)	State Pa	cemetery, arklaw						5/2012 wden i	Ro	ckvil	lle, 1	
Bal	permi Depar Impor any ir		21. Signature of Funeral Ser	vice Licens	RAn	m	ling		Name and			,	St., Ro				20850
23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.									the mode	of dying,	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between
	Medical		Immediate Cause (Final disease or condition resulting in death)		a		c Ovar		ı Can	cer				_		-	Onset and Death
	Examiner	er	Sequentially list conditions,		b. — Due to (c												
	ansit	amin	if any, leading to immediate Cause (Disease or injury that initiated events	or as a cons	equence of):												
_	icate be executed i physician and is the burial-tansi	cal E)	resulting in death) Last	L	Due to (d	or as a cons	equence of):										
68760	tificate ng phys as the	Medi	d								-						
Вох	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-ransit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 conths? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death   4   Pregnant at time of death   9   Unknown   Unknown   1   Live Birth 2   Fetal death   1   Live Birth 2   Live Bir						☐ Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery Month Day Year			
	The law requires that the ate has been signed by the page 2 should be detach	þ	Part II. Other significant con	nditions co	ntributing to de	ath but not	resulting in t	he und	derlying ca	use give	n in Part I						e cause of death?
ords	v require	leted											1 L				ably 4 X Unknown sy findings available
Division of Vital Records,	sician; The law octificate has the sirector, page 2 standards.	Completed											autor perfo	OSV	p		pletion of cause of
/ita	ysician; is certific director,	Be	25. Was case referred to med examiner?  1 ☐ Yes 2 ☒No	1.0	lospital:		U 50/0 ·		. □ Do.	Other	e of Deat						
) ot	ttending Phy death. tor: After this the funeral o	ate: To	27. Manner of Death  1 X Natural 5 Pe	endina	28a. Date o		ER/Outpa 28b. Tim inju	e of		c. Injury a work?	at	2	ne 5 🔀 Resid 8d. Describe h				
ISIO	Attend or death ector: A by the 1	Certificate:	2 Accident In	vestigation ould not be termined	28e. Place o		home, farm,	, street	M t, factory, o		es 2 🗌	-	28f. Location (S	Street a	nd Numbei	or Rural F	Route Number,
2	pital or ours after eral Dir filled in					g, etc. (Spec						_	City or Tow				
	To the Hospital or Attending Physiciam, within 24 hours after death.  To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	(Check 271 Medi	cal Examii	ician: To the be ner: On the basis e Practitioner:	s of examina	tion and/or in	vestiga	ation, in my	y opinion	, death occ	curred at t	the time, date a	nd plac	e, and due	to the caus	e(s) and manner stated.
	S sight with the sight of the s		29b. Signature and title of ce	rtifier	\ \		_			lcense r	number				ate signed		ay, Year)
	,-		30. Name and address of per	son who c	ompleted cause	d death (It	em 28a) (Typ	e, Prin	nt)	142				10/2	22/20	12	
	Ctot		G. Coleman, MD  31. Date filed (Month, Day, Ye		5 Picca					e, N	Ш ———						
	Stat Registra		OCT 23		E		nature da	Ma									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Jones ester 0 017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMICO HENINSULA KIGIONAL Medical 34415641 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months (Month, Day, Year) 214-32-1938 Director 1 M 2 □ F Vov. Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 Yes 2 🗌 No Princess Maryland Somerse 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2185 12366 Somerset 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married è within 72 hours after 1 ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th end Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) aundromat Maintenance 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jone homas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health e item 27 l Somerset Ave. , Autici, Princes Ame, MD, 21853 Bertie Jones Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite eny injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/12 Princess Anne, MD Zion Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Ward Jr. F. H. Princess Anne, MO, 21853 Hampden Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS. Fnysician/ 1 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): HIN Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran o (or as a consequence of) resulting in death) Last attending physician Physician/Medical 4 Box 68760 the as IF FEMALE: use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day 5 Other (specify) Yes 2 No ate has been signed by the page 2 should be detached g Unknown g Unknown Division of Vital Records, P.O. Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlyich cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely within 2 To the only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year, MD D-7 1972 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per Rd Hermon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

SL+3

7			Please	Type or Pri							-	_	<b>).</b>		
30			For State Registrar	State of Ma	aryland /	•	rtment tificate			nd Menta		201	2 35984		
0	Physicia	an/	1. Decedent's Name (First, Middle, Las	st) JGLAS P. JI	- NGFN	0071	inouto	0, 0	- Cutin	Mor	e of Death	Day Year 17, 2012	3. Time of Death		
	Medic Examir		4a. Facility Name (if not institution, give	street and number)	71/0171/		-		Location of I	Death	OBER	4c. County of Death			
2	Funeral	P	HARFORD MEMORIAI  5. Social Security Number 6. S		e (In yrs. last bin	thday)	HAVRE DE GRACE         HARFORD           y) _lf Under 1 Year   lf Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign)								
21/01/01	Director			<b>X</b> M 2 □ F	66		Months	Days	Hours			<sup>ar)</sup> 1946	NEW YORK		
0	uyland a-f show ïed at	Director	10a. State 10b. County	1 M2537	•	City, Town or Location  CAPE MAY COURT HOUSE  10d. Inside Cit 1   ▼ Yes									
	the Ma or 28a e notif	Dire	JERSEY CAPE  10e. Street and Number	MAY									g. Citizen of What Country?		
(9)	th with ns 23a must b	Funeral	3 KINGS LANE					082				UNITED	STATES		
6	fter dear , or iter aminer	ρ	11. Marital Status 1 ☐ Never Married 2 🌠 Married	1 ☐ Never Married 2 🔀 Married Armed Forces? 1 🖂 Yes 2 ☐ N				y Cubar	n, Mexican, F	n? (Specify Yes Puerto Rican, e	or No- tc.)	14. Race - Am Black, Wh	ite, etc.		
7.00	ours a atural' cal Ex	eted	3 Widowed 4 Divorced	Year or Dates.			Yes 2				40		HITE		
36 - 4 21215-0036	iin 72 h ie. <b>han "n</b> <b>e Medi</b>	Completed	(Specify only highest grant Elementary/Seconday (0-12)	+)	(Give ki	nd of work NOT use r	done du etired)	uring most o	f working	10	b. Kind of Busines	·			
36	Hygien Hygien ther ti	Be C	17. Father's Name (First, Middle, Last)	4			PROPI	RIET		s Name (First. I	Ainlette Adei		RANCHISE		
33-	ld be file Mental I arked o atic eve	일	JOHN JENSEN							GEENS	niddie, ivial	en Surname)			
Mar	12 shou alth and 27 is m r traum		19a. Informant's Name/Relationship (T) DEBORAH J. JENSE		195	-						y or Town, State, 2 JERSEY 0			
/ nore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🏋		20b. Place o cemete SEASII	of Disposi	ition (Name	e of ner place	e)	Date 0/19/20	20	c. Location - City o	or Town, State		
/ Baltimore	permit. Pa Departmei Importani any injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service License		SEASIL					UNERAL			NEW JERSEY		
	8 2 E 8 9		Les Sax	t- Colon	and the David	Д	552	LEW	$\Pi S ST$	REET, H	AVRE	DE GRACE	1		
4	Physician/		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line			5h			rdiac or respira	tory arrest,		Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as	sequence	of):		001							
	¬ ==	iner	Securitiesly list conditions if any, leading to immediate cause. Enter Underlying	any, leading to immediate use. Enter Underlying  Due to (or as a consequence of):											
5	be executed sician and burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence	of):									
	ate be e physicia the bun	edical		d											
> ×	death certificate ne attending physed for use as the	an/M	ZOD. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	h 3 🗆	Ectopic pre	eonancy	,			23d. Date of d	elivery		
Constant	he deatl y the att iched o	Physician/Medio	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of death		Other (spec					Month	Day Year		
% P.0	requires that the death certificate to been signed by the attending physishould be detached for use as the I		Part II. Other significant conditions of	ontributing to death bu	ut not resulting i	in the un	derlying ca	use give	en in Part I.	236			to the cause of death?		
S R N Records	w requi	Completed by								248	. Was an autopsy	24b. Were a	autopsy findings available completion of cause of		
N.S.	r: The la icate ha r, page		05.14								performed Yes 2	d? death? No 1 ☐ Ye	es 2-15 No		
Vital	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital:	ent 2 🗆 ER/Ou	ıtnatient	3 🗆 DOA	Lou	r-	(Check only on	·/	e 6 🗆 Other (Spe	noifel		
D.	ding Phy h. After thi funeral (		27. Manner of Death  1 Natural 5 Pending	28a. Date of injur (Month, Day)	y 28b. 1	Time of njury		c. Injury work?	at	28d. Des		njury occurred	<u> </u>		
Division	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director, After this certificate has been sign completed filled in by the funeral director, page 2 should be	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, fa . (Specify)	ırm, stree			165 2 110	28f, Loc	ation (Stree or Town, S		ural Route Number,		
Ω	fospital thours a funeral C ed filled	Medical (	29a. Certifier 1 Certifying Phys	sician: To the best of a											
	No the Position 2.	Me	only one) 3 Certifying Nurs 29b. Signature and title of sertifier	se Practioner: To the b	pest of my know	ledge, de	eath occurre	d at the	time, date ar	nd place, and du	e to the cau	ise(s) and manner a  Date signed (Mon	s stated.  th, Day, Year)		
			· CYY	Nac			0	00	562	.96	1	0-17	-2012		
			30. Name and address of person who de Jason Birr	ompleted cause of de	ath (Item 23a) (	lype, Pri	outh	Un	ion A	venue	Hav	re de Ga	e cause(s) and manner stated. Is stated. Ith, Day, Year) - 2012 TC/MD 2108		
В	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1	Registra	r's Signature	9	borks	1					/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death October Jones 1920 M Albert 2012 orman 10 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death hester Genera Dorchester DONITO ambridge If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 218-24-250 1 M 2 □ F Months Days Hours Min. APr:106 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No odesdal 10e. Street and Number 10g, Citizen of What Country? 59 entennia 6 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █ No Specify: If Yes, Give Year or Dates: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vorman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46038-1151 Nerthwood Harmon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery Cambrio Bethel 120/12 4 Donation 5 Dother (Specify) Name and Address of Facility
envy Funeral 21. Signature of Funeral Service Licensee Home, P.A. Cambridge 510 Washington 23a. Part . Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Prox Jete Immediate Cause (Final Concer Metalkhi disease or condition resulting in death) Due to (or as a consequence of): peratur a lune Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of HINOHO 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

and

Important: If it any injury or o once.

**Department** 

**Physician** 

/Medical

10a. State

Examiner

**Funeral** 

**Director** 

28a-f show

Funeral Director

Be Completed by

ဂ္

item 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the "hedical Exprimer must be notflied

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

Examiner

Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical ieral Director: After this certific filled in by the funeral director, Be Certification: To

this certificate

Hospital or Attending 24 hours after death.

To the Hospital of within 24 hours a To the Funeral D

IF FEMALE:

2 - No

24b. Were autopsy findings available prior to completion of cause of death? 2 1No 1 □Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 29c. License number

CAMBRIDGE

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

Hospital:

1. Inpatient

Date of Injury (Month, Day, Year)

THANKY 503 MOMAN

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a, Certifier

Medical

State

Registrar

OCT 23

5 Pending

investigation

6 Could not be determined

Registrar's Signature

2 ER/Outpatient 3 DOA

Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:25рм Arthur Wade Joyner October 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 5. Social Security Number 245–56–9 9 9 9 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Wilson,NC (Month, Day, Year) Director 1 ÅM 2 □ F Sept 25, 1941 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b.County Baltimore 10c. City, Town or Location Towson10d. Inside City Limits Completed by Funeral Director MD 1 Yes 2 No 10e. Street and Number 5106 Midwood Avenue 10f. Zip Code 2121 2 10g. Citizen of What Country? ŪSA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter 10th Be 17. Father's Name *(First, Middle, Last)* Leonard J*o*yner 18. Mother's Name (First, Middle, Maiden Surname) မ Ida Odell Melton 19a. Informant's Name/Relationship (Type, Print) Yvonnia Joyner /wife 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 5106 Midwood Avenue Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Rest Haven Cem Wilson, NC 10-27-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hamilton Funeral Chapel WCOE-lance 726 Tarboro Street W Wilson, NC 27893 Pur 1. Enter the disease, complications that caused slock, or heart failure. It only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (UN. Cance cell disease or condition resulting in death) north Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 □ Nursing Home 5 □ Residence 6 🕅 Other (Specify) ₩Sριζ ဂ္ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one title of certifie 29b. Signature p 29c. License number 29d. Date signed (Month, Day, Year) 58303 October 16 2012 ss of person who completed cause of death (Item 23a) (Type, Print) TUNSON an) VES 100265 31. Date filed (Mont) 32. Registrar's Signature State 1 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25 per med cert G933 11/14/12 dk
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobe Day 20 Clara Alice Jarman 2012 1002 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PENINSWA REGIONAL MEDICAL NICOMICO Center SALISBURG 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 220-66-4617 1 □ M 2 🛣 F 71 April 21. 1941 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 E. East Street 21875 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examir ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XX No Specify. 3 Widowed 4 K Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 8 homemaker home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Fulton Hearn Elizabeth Virginia Bradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Taylor (companion) 104 E. East Street Delmar, timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 10-23-2012 Delmar, Delaware . Signature of Funeral Service License 22 Name and Address of Facility.
Short Funeral Home
13 East Grove Street well Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Septicemua disease or condition resulting in death) Medical Du to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and debached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or mjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?

1 Yes 2 No
9 Unknown 4 Pregnant : 9 Unknown Month Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage renal disease within 24 hours after death.

To the Funeral Director. After this certificate has been sit completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown Peripheral vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗆 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) OK 10/20/20/2 0007096 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ODE. Carroll St. md. 21801 SAlisbury 32 Registrar's Signatur State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 35989 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER LONNIE B **JOHNSON** 2012 11:25 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heron Point - Talbot Wing Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Aug 18 1914 054-38-9407 Director 98 1 □ M 2 🕅 F Texas Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director MD Kent Chestertown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 501 East Campus Ave. Rm 2032 21620 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lonnie Bennett Sweeney Mary Alice Pyeatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Johnson (son) 1592 Rosewood Lane York, PA. 17403-4424 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Other (Specify Kent Cremation Services 10/25/12 4 Donatton 5 Smyrna, DE. 22. Name and Address of Facility Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 M00510 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ Unknown Unknown signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSPHAGIA AND HEMIPLEGIA SECUNDARY TO 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hin 24 hours after death.

the Funeral Director; After this certificate has moletely filled in by the funeral director, page 2. autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Yes Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041587 25 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 21620

State Registrar Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7:19 20 Kendrick 2012 Nancy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 213-38-1255 Director 1 🗌 M 2 🕱 F 78 09/14/1934 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 52 S. Cannon Avenue 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black White etc. 1 Never Married 2 M Married ρ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) filed within Homemaker Domestic 12 event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o Mental 2 Unknown Sullivan Viola (Unknown) Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Kendrick / Husband 52 S. Cannon Ave., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/24/2012 Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and peat Immediate Cause (Final 61626 110 OR SCOB Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician of the detached for 11se as the bearing Completed by Physician/Medical The law requires that the death certificate be 1F FFMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 9 Unknown se contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço 0,0 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 မှ 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Turse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mate signed (Month, 29b. Signature and title of confiner 30. Name and address completed cause of death (Item) 8 Z 31. Date filed (Month trar's Signature State

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012<sup>Yea</sup> October George Ernest King, Sr. 3:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11667 Heart River Ct. Waldorf Charles **Funeral** 7. Age (In vrs. last birthday. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Hours Min (Month, Day, Year) Sept 22, 1938 **Director** 215 36 4056 1**XX** M 2 □ F 74 Washington DC Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles Waldorf 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11667 Heart River Court 20602 United States within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with h and Mental Hygien 7 is marked other th 10 Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Herbert King, Sr. Elsie Mae permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Mendoza (daughter) 11667 Heart River Court, Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 10/19/2012 Clinton, MD 21. Signature of Fun <sup>22. Name and Address of Facility</sup> Lee Funeral Hone, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 MO1140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 as the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 NO မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 24 hours after death Funeral Director; A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely

within 2 To the

State Registrar (Check

30. Name and address of person who

egistrar's Signatur

ood

completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License numbe

35992

			= State Registrar			Certif	icate of i	Death			Reg. No.			
	Die eter		1. Decedent's Name (First, Middle, Last)		·					Date of Dea	ath		3. Time of Death	1
	Physicia Medic		SUE HELEN K	CALLMYER					þď	TÖBE	$R^{-1}$	9 2012	8:58 A	М
- 3	Examir		4a. Facility Name (if not institution, give s	treet and number)		46	o. City, Town, o	r Location of	f Death		4c.	County of Deat		
			FREDERICK M	EMORIAL H	HOSPI	TAL	FREDE	RICK				REDERI		
	Funeral		Social Security Number 6. Sex	7. Age (I	In yrs. last bir		Under 1 Year			Date of Birl	th		hplace (State or Fore	ign
	Director		215-18-8891 1	M 2₺F Q	9	Yrs.	onths Days	Hours	1. "	Month, Da			intry)	
	A		Usual Residence of Decedent						No	v. 21	, 19	22 PA		
	sho	Director	10a. State 10b. County	1	10c. City, Tow								10d. Inside City Limi	ts
	Mary 18a-1	<u>8</u>	MD Freder	ick	Fr	ederi	.ck				1 ☐ Yes 2¾☐ No			
	the P	□	10e. Street and Number			1	10f. Zip Code			T	10g. Cit	izen of What Co	untry?	
	with with	Funeral	272-A Dill Avenue				217	<b>01</b>		1	1	USA		
	eath fems	[5	11. Marital Status	12. Was Decedent Eve	er in U.S.		Decedent of H					14. Race - Ame	ican Indian.	_
ဖွ	P I	ρ	1 ☐ Never Married 2 ☐ Married	Armed Forces?	o		s, specify Cub		Puerto Ricar	n, etc.)		Black, White	, etc.	
ဋ္ဌ	rs af	þ	3 H Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 1 1	Yes 2 No	Specify:				Specify: White	. e	
ည	within 72 hours after death with the Maryland glene. er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a		's Usual Occup		-4 di'		16b. Ki	ind of Business/	ndustry	
7	in 72	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)			of work done OT use retired)		or working		-			
2	with 'gien'		12		Se	creta	ry				Ec	ducation	1	
B	be filed ental Hy ked oth Ic event	Be	17. Father's Name (First, Middle, Last)						r's Name (Firs		Maiden S	Sumame)		
<u>a</u>	d be Vent	မ	John Virgil Greene					нет	en Eck	man				
an	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Itam 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type	e, Print)	19	b. Mailing A	ddress (Street	and Number	or Rural Rou	ite Numbe	r, City or	Town, State, Zip	Code)	
Σ	d 2 salth allth		Stephen Kallmyer/	Son	27	'2-A D	111 Av	enue.	Freder	ick.	MD 2	21701		
ē	1 and of Heal	1	20a. Method of Disposition		20b. Place of	of Dispositio	n (Name of		Oct.			ocation - City or	Town, State	
Baltimore, Maryland 21215-0036	ent cent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Gate c	ery, cremato. of Hea	ven Cei	nete <b>r</b> v		$\frac{23}{12}$	Silv	ver Spri	no MD	
薑	artm orta Inju	1	21. Signature of Funeral Service Licensee						20				ing, in	_
ñ	permit. Page 1 a Department of H Important: If Ite any Injury or ot			7-0-		500	me and Addre	COTIL	ns Fur lyd W	neral	Hom	e Inc.	,MD 20901	
		_	23a. Part 1. Enter the disease, or compli	cations that caused th	ne death. Do							r phring		-
٠.	0		shock, onheart failure. List only one Immediate Cause (Final	cause on each line.	0	1.	ooco o. c.j	.g, 525.1 25 6	4.0.40 01 100	piratory arr	ou,		Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	.0	2+4	OKE	9						Onset and Death	
	Examiner		Tools and the second se	Due to (or as a c	onsequence	of):								
		P.	Sequentially list conditions, b	D		- 0								
	od it	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence	oi);								
	and and	xal	that initiated events cresulting in death) Last	Due to (or as a c	onesaniance.	off:								_
_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bugaragest		and the second s			,-								
68760	ate b	/Medical	d	l										
8	artific ding   se as	Ž	IF FEMALE:	3c. If yes, outcome of	prograncy						$\neg$			
×	itten for us	jan	23b. Was decedent pregnant in the past 12 mopths?	1 Live Birth 2	Fetal deat			Э			1	23d. Date of deli Month	very Day Year	
ŏ	e dea the a	Physician	1 ☐ Yes 2 ☑/No 9 ☐ Unknown	4 ☐ Pregnant at til 9 ☐ Unknown	me of death	5 🗆 00	her (specify) _					WORLD	Day lear	
Division of Vital Records, P.O. Box	at th d by detac	P	Part II. Other significant conditions con	tribution to death but	not resulting	in the under	dvina cause di	ven in Part I		220 Did to		aa aantsibusta ta	the cause of death?	_
	es th	Completed by	Advanced	Dem			,, 3.		1				/	
ğ	equir een (	)tec	1000000	10 ( 10)	end 1	a					res 21	No 3 □ Pr	obably 4 4 Unkno	<i>N</i> n
8	law n	D D								24a. Was a autop		24b. Were aut prior to c	opsy findings available ompletion of cause o	e f
æ	The ate Page	ပ်								perfo	rmed?	death? 1 ☐ Yes	2 🗆 No	
<u>ra</u>	sien: artific actor.	Be	25. Was case referred to medical examiner?				26. P	ace of Death	(Check only	one)				
⋝	hysic li dire	၉	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient	2 🗆 ER/O	utpatient 3	DOA Oth	er: 4 🗆 Nurs	sing Home	5 🗌 Resid	lence 6	Other (Speci	fy)	
ð	ng Pl	ţë:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y		Time of injury	28c. Injur work	y at		Describe h				
9	endil eath. or: Ai	fica	2 Accident Investigation					Yes 2 □ N	No					
<u>.s</u>	r Att	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5		ırm, street, f	factory, office					Number or Run	al Route Number,	
á	talo irsaf al Di			Sanding, oto. (c	эрсску					City or Tow	n, Siale)			
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funarial Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the budgateds.	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	ian: To the best of my	knowledge,	death occu	rred at the time	e, date and p	place, and du	e to the ca	use(s) an	id manner as sta	ited.	
	the H nin 24 tha F tha F	¥.	(Check 2 Medical Examine only one) 3 Certifying Nurse	Practitioner: To the be	est of my kno	wiedge, dea	th occurred at t	he time, date	and place, at	me, date a nd due to th	na piace, ne cause(	and due to the c s) and manner as	ause(s) and manner st stated.	ited.
	4.7		29b. Signature and title of certifier				29c. License			:	29d. Date	e signed (Month	Day, Year)	
	, 10		1 Diane V	uckert	-cra	P	R11	5108	\$		10	119/1	2	
			30. Name and address of person who cor	npleted cause of deat	th (Item 23a)	(Type, Print)	1			,				_
		0	Diane Rucker	CRNP <	514	Trai	1 AJ	9	1-re	der	rick	C, MD		Ü
	Stat		31. Date filed (Month, Day, Year)	32 Registrar's		6.0	2.8	-				/		
	Registra	Tr.	nct 2 2 2012	1 172	. 1	JEIGHE	4							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kaessinger Month Martha -DVe 6:10PM October 2012 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medstar Montgomery Medical Center 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 205-12-4563 Director 1 M 2 X F 86 Nov. 1, 1925 PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 KNo Montgomery Silver Spring 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 15320 Pine Orchard Drive, Apt. 2G 20906 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ral", or iten Examiner r Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2X No Page 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 SpecifyWhite 1 Yes 2 SNo Specify "natural", 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's Aide Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Julia Dmytryk and Mental F John Markovich ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Kaessinger Coupe/Daughter f Health aitem 27 14 Middlebridge Court, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. Oct. 20, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 4 Donation 5 Other (Specify) 2012 Alexandria, VA permit. 21. Signature of Funeral Service Licer Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate et and Death Interval Between Immediate Cause (Final Physician/ Cerebral Vascular years disease or condition Medical resulting in death) Examiner pertension yeurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to ( as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery ò in the past 12 months? be detached g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipidemia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hypothyroin, Sm 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) DOA After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2 29c. License number ID October 16,2012 pleted cause of death (Item 23a) (Type, Print) 10800 Steamboat Landing, Columbia, MD 21044 30. Name and address of person who comple Rita E. King, MD 1 31. Date filed (Month, Day, Year, 18 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per / fh. g934 12-12-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 18,2012 Physician/ Alain Kenou 1850 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 71968 6/25/ 217-81-1816 Cameroon Director 1 XM 2 F 44 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11404 Stewart Lane Apt.B1 20904 Cameroon death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Black should be filed within 72 hours after and Mental Hygiene. Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Hotel 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Odette Tchanque Joseph Kenou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904Page 1 and 2 strength a Health a tant: If item 27 is Madeleine N.Meguia/Wife 11404 Stewart Lane Apt.B1 Silver Spring,Md permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 N Removal from State Family Cemetery 11/17/2012 Dschang, Cameroon 4 Donation 5 Other (Specify Funeral Service Liver ee 21. Signature PHTTE TPAd Des RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute respiratory failure Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialbeen signed by the attending physician should be detached for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 lymphoma, neutropenic fever, AIDS 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law has. autopsy 1 Yes 2 X No After this certificate Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 5 Pending 1 X Natural 24 hours after death. Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) Oct.19,2012 29c. License number 29b. Signature and D63579

State

30. Name and address of person who completed Maria J. Tayag MD

OCT

23 2012

1500 Forest Glen Rd. Silver Spring, Md

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Ι. Kelley October 20T2 Geneva 4:54 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours 05/23/1928 84 **Director** 248-38-3046 1 □ M 2 🛛 F Yrs Virginia Usual Residence of Decedent ed other then "neturel", or Items 23a or 28e-f show event, the Wedigal Examiner must be nutified at 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Montgomery 1 X Yes 2 No Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 522 Woodston Road 20850 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Depertment of Health and Mentel Hygiene. Importent: If item 27 is marked other then "neturel", or I eny injury or other treumatic event, the Medical Examiny once. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Technician</u> Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Sadler Carlos Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14822 Southlawn Lane, Rockville, MD 20850 James Michael Kelley (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 3 cemetery, crematory or other plant Parklawn Memorial
Park
Park 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25, 2012 Rockville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive, M00689

DeVol Funeral Home, 10 East
Gaithersburg, MD 208

23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 0 Approximate Interval Between Onset and Death Pheumonia Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Accident Vehicle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ettending physician and if for use es the burlal-transit Fracture Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 そりもりこ IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day ate has been signed by the page 2 should be detached 9 Unknown 3 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? To the Hospital or Attending Physiciem: me, within 24 hours after death.

To the Funerel Director. After this certificate to completely filled in by the funeral director, page. 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending motor vehicle accident 1 ☐ Yes 2 🔯 No 112/2012 1530 Investigation 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) intersection of Brink Rul & Laytonsville Rul. Laytonsville, Mary Incl 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Engra, us D0057124 10/211/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holecular Drive Suite 206 Rockville MD 20850 Truona Bao 10/10 31. Date filed (Mooth, Day, Year) State 23 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tregor Medical 4a. Facility Name (if not institution, give street and humber) Examiner 4c. County of Death ryland Health allegheny **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min **Director** Feb 03 Maryland or 28a-f show be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits West 1 Yes 2 No Mineral Virginia New Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26743 HC 75 Box 45 A United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1963-65 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Heavy Equipment Operator County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Gregory Kinsey, Sr. Dorothea Elizabeth Rau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
90 Waverly Dr., Apt. BB302, Frederick, MD 21702 Loretta Paynter / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 23, 20c. Location - City or Town, State Resthaven Memorial Gardens 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Frederick, Maryland al Se / ce Licensee 21. Signature of P.A. Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Fart 1. Enter the disease shock, or heart failur. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or andition Onset and Death Physician Medical resulting in death) **Examiner** Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE nse es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_ 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has r director, page 2 autopsy performed?

Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes ည 1 Inpatient 2 KER/Outpatient 3 IDOA hin 24 hours after death. the Funeral Director: After this mpletely filled in by the funeral o Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2, To the F complet 3 Certifying N Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number erson who completed cause of death (Item 23 UK1 00

DHMH 17 Rev 06-2011

State

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Beverly Kingsbury Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 1 □ M 2 🏝 F **Director** 577-56-0246 71 09/20/1941 Washington, DC 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 K Yes 2 □ No MD Prince Georges Upper Marlboro 10e Street and Number 10g. Citizen of What Country? 23a Funeral 904 Falcon Drive 20774 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 'natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates. Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Gray Corrine Clarke of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Falcon Drive Upper Marlboro, MD Karen Kingsbury - Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 10/31/2012 Brentwood, Maryland 21. Signature of Funeral Se Ice Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CAMSIAC Sequentially list conditions, Examiner cause. Enter Underlying ME)17.60 Cause (Disease or injury for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): ding physiciar Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No Yes 2K No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes 2 🔀 No ၉ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 20055107

State Registrar

DHMH 17 Rev 06-2011

Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsion Berhane,

3001 Hospital Drive,

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:40p.m<sup>M</sup> October 0 Doris Jean Longley Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown . Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** (Month, Day, Year) Months Hours 215-36-3650 **Director** 1 □ M 2X F 05/05/1942 Usual Residence of Decedent 70 D.C. iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X☐ No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27370 North Sandgates Road 20659 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced White or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John B. Robertson Bertha Steele and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 and 2 s Health s William F. Longley Sr./Husband 27370 North Sandgates Road, Mechanicsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) 10/26/2012 Mechanicsville, MD of Peace Cem Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final exacero Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Other (specify) Day Pregnant at time of death ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 🗌 Yes 2 🗌 No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iours after death.

neral Director: Aft
filled in by the fur Accident Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2) Rme 22650 Cedar Lane Court, Leonardtown, MD 20650 Shah, Avani D.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

OCT 24

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:00p<sup>M</sup> Edna Μ, Lucas October 13 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cherrylane Nursing Home Laurel Prince George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) ay 1,1932 Months Hours **Director** 1 🗆 M 2 🗐 🕊 227 58 6891 80 Virginia Мау Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Yes 2 No MD Prince George' Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20724 235 Federalsburg South 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. ģ 1 Never Married 2 Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Black "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Aide Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Malden Surname) Nancy Brown Henry Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 Federalsburg S. Laurel, MD 20724 Sylvester Lucas/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Hope Bapt. Church Cem Oct. 20,2012 King George, Virginia 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Cadell Brooks Funeral Home 25662 AP Hill Blvd Port Royal, Virginia 22535 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ triton disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): nding physiciar. Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. Her this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bowie SYE 14333

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chata	partment of Health and Mental Hygiene							
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death Reg. No. 2 1 2 350	) ( (						
	Physicia		Annie Fooks Lyon	2. Date of Death 3. Time of De Month Day Year							
وإضمام	Medic Examir		4a. Facility Name (if not institution, give street and number)	October 20, 2012   10:47   4b. City, Town, or Location of Death   4c. County of Death	P						
	J.		Ammahl Home	Olney Montgomery							
	Funeral Director		5. Social Security Number 219-36-7816 6. Sex 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ay) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or I							
			Usual Residence of Decedent	Dec. 25, 1908 MD							
	yland f sho	ctor	10a. State 10b. County 10c. City, Town or L	Location 10d. Inside City L	Limits						
	e Mar r 28a- notifi	Director	MD Montgomery Brooke		□ <b>x</b> No						
	vith th			10f. Zip Code 10g. Citizen of What Country?							
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	20833  Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Reck White etc.							
36	after d	۾ ا	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 → No Specify:  Black, White, etc.  Specify: White							
8	ours a atural cal Ex	Completed	3 <sup>™</sup> Widowed 4 □ Divorced If Yes, Give Year or Dates.  15. Decedent's Education 16a Dec								
215	n 72 h an "na Medii	du	(Specify only highest grade completed) 16a. Dec (Give condary (0-12) College (1-4 or 5+) life.	redent's Usual Occupation 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. NOT use retired							
21	withii			Teacher Education							
and	e filed ntal H ed otl	To Be	17. Father's Name (First, Middle, Last) Robert Percy Soper	18. Mother's Name (First, Middle, Maiden Surname)							
ž	ould bid Mer			Mary Virginia Soper							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		T TT TT TT TT	iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L 6 Tanterra Way, Brookeville, MD 20833							
ore,	of He of He if item		20a. Method of Disposition 20b. Place of Disp	position (Name of Date 20c. Location - City or Town, State							
ij	t. Pag tment tant: jury c		4 □ Donation 5 □ Other (Specify) Metropoli	tan Crematory 2012 Alexandria, VA							
Bal	permi Depar Impo any ir	. 10	21. Signature of Funeral Service Licensae	22. Name and Address of Facility.	ij						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	000 University Blvd. W., Silver Spring MD 20	901						
-4	Hiysician/	8 1	snock, or neart tailure. List only one cause on each line. Immediate Cause (Final	Interval Betwee							
	Medical Examiner		disease or condition resulting in death)  a. Atherosclerotic Depute to (or as a consequence of):	Lsease	-						
		ē	Sequentially list conditions, b.								
	ited d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or, Irijury								
	an and rial-tra	EX	that initiated events c. Due to (or as a consequence of):								
9	death certificate be executed ne attending physician and ed for use as the burial-transit	dical	d								
687	ertifica ding p	/We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								
ŏ	eath c atten 3 for u	iciar	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)  23d. Date of delivery Month Day Year	. 9						
P.O. Box 687	the d by the tached	hys	9 Unknown	A							
<u>ď</u> .	The law requires that the death certifica ate has been signed by the attending page 2 should be detached for use as to	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the Hypertension								
rds	equire equire hould	eted	-57701011011	1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unix	nown						
ဓင္ဓင	has he 2	ը		24a. Was an 24b. Were autopsy findings availa autopsy performed?							
<u>س</u>	an: Th tificate tor, pa		25. Was case referred to medical	1   Yes 2   No							
Ĭ	nysicia iis cer direc	8 2	examiner? 1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	low							
ō	ing Pr	Certificate:	27. Manner of Death 1 △ Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury								
Sior	death death stor: A y the f	M 1 Yes 2 No									
Division of Vital Records,	al or A s after I Direct	reet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	or be hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	25. Was case referred to medical examiner?   25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   1									
	the F										
	- 3 = 3		29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)  D55931 0ct. 22. 2012							
	•	1	30. Name and address of person who completed cause of death (Item 23a) (Type,	3300 22, 2012							
			T. Lisa Ng, MD 4000 Olney-Laytonsv	ville Road, Olney, Maryland 20832							
	State Registra	7	31. Date filed (Month, Day, Year)  OCT 2 3 2012  32. Registrar's Signature	the state of the s							
_		_									